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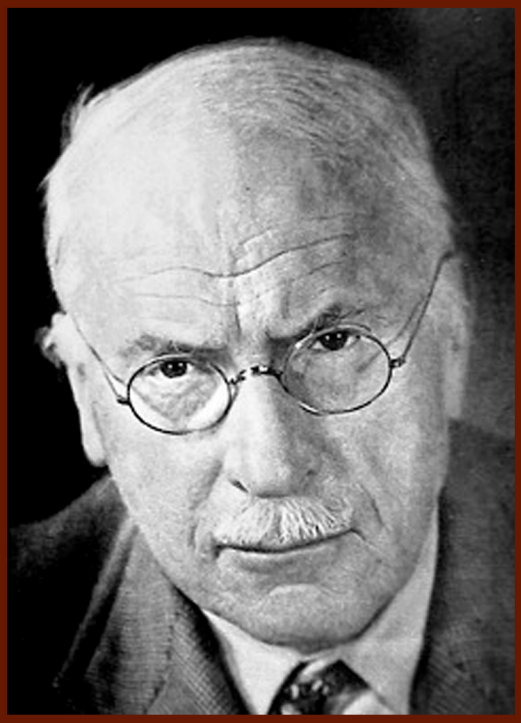
## Person of the Issue



Carl Gustav Jung (1875-1961)

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# The Team

The Editorial Board is comprised of nationally recognized scholars and researchers in the fields of Psychology, Education, Social Sciences, Home Sciences and related areas. The Board provides guidance and direction to ensure the integrity of this academic peer-reviewed journal.

# Message from Editors

Welcome to Volume 2, Issue 3. Throughout this period, IJIP focused on improving our policies, format and facilities provided, keeping in mind our authors; because we love our authors and our authors love us!

Our main purpose is to put forward a variety of psychological ideas and researches to the world. We also aim to develop meaningful relationships with good publications around the world. We do this with the aim of providing advantage to us and to them. Some of the major publishers and institutes we have tried to connect to be Google, Academia, OAJI and Research Bible. We have also been given a chance to work with Publishing Police at a very low cost and high quality benefits.

IJIP has been rewarded with a No. 1 position with a score of 19.67 on the Directory of Science which lists the top 100 science journals throughout the world. Our impact factor is 4.50, evaluated by Index Copernicus International, from Warsaw, Poland.

In the following issue experts in varying fields of psychology have shared their ideas related to psychological problems and their solutions. We are grateful to these authors for allowing us to publish their researches and ideas in this issue. We would also like to thank other writes, and our beloved readers for providing a strong support and being a part of team.

**Prof. Suresh Makvana, PhD***
(Editor in Chief)
**Mr. Ankit Patel****
(Editor)

*Email: ksmnortol@gmail.com
**Email: info.ankitpatel@asia.com

Index of Volume 2, Issue 3, No.1

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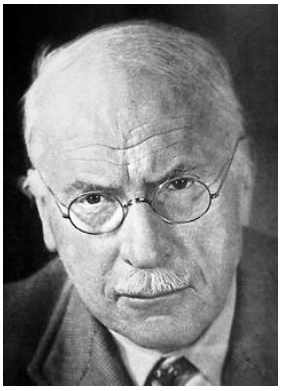
# Person of the Issue: Carl Gustav Jung (1875-1961)

Ankit Patel[1]

| | |
|---|---|
| **Born** | 26 July 1875<br>Kesswil, Thurgau, Switzerland |
| **Died** | 6 June 1961 (aged 85)<br>Küsnacht, Zürich, Switzerland |
| **Alma mater** | University of Basel |
| **Field** | Psychiatry, psychology, psychotherapy, analytical psychology |
| **Spouse** | Emma Jung |



Carl Gustav Jung (1875-1961) had a significant contribution to the psychoanalytical movement and is generally considered as the prototype of the dissident through the impact of his scission and the amplification of the movement he created in his turn (analytical psychology).

Jung was the son of a Swiss reverend. He completed his medical studies, specialized in psychiatry and joined the staff of Burgholzli, the renowned psychiatric hospital in Zurich, run at that time by the famous Dr. Eugen Bleuler.

In 1902-1903 he attended a traineeship in Paris with Pierre Janet, and then returned to Zurich and he was called senior physician at Burgholzli.

It was in this context that Jung was introduced to Freud in 1907. Freud would be seduced by the prestige and personality of Jung and would soon see in him the spiritual son that could ensure the survival of psychoanalysis, so much so as Jung was not Jewish.

Intense, professional and friendship bonds form between the two, with an ambivalence dominated by the inclination of Jung to underestimate himself in comparison with Freud, the fervor of his devotion to the "father" of psychoanalysis and oneiric hostility (emphasized by Freud in the common interpretation of dreams).

Jung had a swift ascension in the hierarchy of psychoanalysis. He became the editor of Jahrbuch.

[1]Cilinical Psychology, Sardar Parel University, Gujarat

In 1908, he traveled to the United States and in 1910 he became the first president o the International Association of Psychoanalysis.

The reluctance of Jung towards the Freudian theory referred to the role of sexuality in the psychic development. In fact, Jung never completely embraced the sexual theory of Freud.

Since 1912 he became more and more distant in his writings, which would cause a scission materialized in 1914 by his resignation from all the positions he already held.

He married Emma Rauschenbach in 1903. They had five children. Even though he remained married to Emma till her death, he had several affairs with other women, the most notable of whom were Sabina Spielrein and Toni Wolff.

**TIME LINE**

| Years | Happenings |
|---|---|
| ***1875*** | Jung is born in in Kesswill, Switzerland, son of a Reformed Protestant pastor, Johann Paul Jung, and Emilie Preiswerk. |
| ***1895*** | Jung enters Basel University to study science and medicine. |
| ***1896*** | Jung's father dies. |
| ***1900*** | Jung graduates with a M.D. from the University of Basel and is appointed assistant at the Burgholzli Psychiatric Hospital, Zurich, under Professor Eugen Bleuler. |
| ***1900-1909*** | Jung works at the Burgholzli Mental Hospital in Zurich. |
| ***1902*** | Jung gets his Ph.D. at the University of Zurich with a doctoral dissertation *On the Psychology and Pathology of So-Called Occult Phenomena*. |
| ***1903*** | Jung marries Emma Rauschenberg. The get five children in the course of time. |
| ***1905-1913*** | Jung lectures in psychiatry at the University of Zurich. |
| ***1906*** | Jung initiates letter correspondance with Sigmund Freud and visits him next year in Vienna. |
| ***1907*** | Jung's first meeting with Freud. He writes the work *The Psychology of Dementia Praecox*. |
| ***1909*** | Jung resigns from Burgholzli. He visits USA with Freud. |
| ***1909*** | Jung also opens his private practice of psychoanalysis in Kuessnacht - he runs it enthusiastically till he dies. |
| ***1910*** | Jung is elected President of International Psychoanalytic Association. He writes *Symbols of Transformation*. Lectures at Fordham University. |
| ***1912*** | Jung declares he is scientifically independent of Freud and publishes *Neue Bahnen der Psychologie* . |
| ***1913*** | Jung resigns as President. His final break with Freud. |
| ***1916*** | Jung publishes *La structure de l'inconscient*. |
| ***1917*** | Jung publishes *Die Psychologie der unbewussten Prozesse*. |
| ***1919*** | Jung's first use of the term archetype (in *Instinct und Unbewusstes*). |
| ***1921*** | Jung publishes *Psychologische Typen (Psychological Types)*. |
| ***1923*** | Jung starts the building of his "tower" in Bollingen. |
| ***1923*** | Jung visits Pueblo Indians in North America. |

| | |
|---|---|
| ***1925*** | Jung's study trip to the Elgonyi of Mount Elgon in East Africa. |
| ***1929*** | Jung's Commentary on the Taoist text *The Secret of the Golden Flower*. |
| ***1931*** | Jung publishes *Seelenprobleme der Gegenwart*. |
| ***1932-1940*** | Jung works as a professor of psychology at the Federal Polytechnical University in Zurich. |
| ***1934*** | Jung publishes *Wirklichkeit der Seele*. He also begins series of seminars on Nietzsche's *Zarathustra*. President (until 1939) of International Society for Medical Psychotherapy. |
| ***1935*** | Jung's Tavistock Lectures, London, on "Analytical Psychology". |
| ***1937*** | Jung's Terry Lectures, Yale University, on "Psychology and Religion". |
| ***1937*** | Jung's study trip to India. |
| ***1941*** | Jung publishes *Essays on a Science of Mythology* with Karl KerÃ©nyi. |
| ***1944-1945*** | Jung becomes professor of medical psychology at the University of Basel, and his *Psychology and Alchemy* is published. |
| ***1945*** | Jung publishes *Nach der Katastrofe*. |
| ***1948*** | Founding of C.G. Jung Institute, Zurich. |
| ***1950*** | Jung publishes *Aion - FÃ¤nomenologie des Selbsts*. |
| ***1951*** | Jung's lecture "On Synchronicity". |
| ***1952*** | Jung publishes *Antwort fÃ¼r Job (Answers to Job)*. |
| ***1955?*** | His *Mysterium Coniunctionis*. |
| ***1957*** | Jung publishes *Gegenwart und Zukunft*. |
| ***1961*** | Jung dies at his home in Kusnacht, near Zurich, at the age of 85, after a short illness. |

*"Thank God I am Jung and not Jungian" (C.G. Jung)*

**CARL JUNG WORKS***

1. Memories, Dreams, Reflections
2. The Red Book: A Reader's Edition (Philemon)
3. The Portable Jung (Portable Library)
4. Modern Man in Search of a Soul
5. The Archetypes and The Collective Unconscious (Collected Works of C.G. Jung Vol.9 Part 1)
6. Synchronicity: An Acausal Connecting Principle. (From Vol. 8. of the Collected Works of C. G. Jung) (Jung Extracts)
7. Psychological Types (The Collected Works of C. G. Jung, Vol. 6) (Bollingen Series XX)
8. The Basic Writings of C. G. Jung (Modern Library)
9. Psychology and Alchemy (Collected Works of C.G. Jung Vol.12)
10. Mysterium Coniunctionis (Collected Works of C.G. Jung Vol.14)
11. Aion: Researches into the Phenomenology of the Self (Collected Works of C.G. Jung Vol.9 Part 2)
12. Four Archetypes: (From Vol. 9, Part 1 of the Collected Works of C. G. Jung) (Jung Extracts)
13. Answer to Job: (From Vol. 11 of the Collected Works of C. G. Jung) (Jung Extracts)

14. Symbols of Transformation (Collected Works of C.G. Jung Vol.5)
15. Psychology and Religion (The Terry Lectures Series)
16. Alchemical Studies (Collected Works of C.G. Jung Vol.13)
17. The Development of Personality (Collected Works of C.G. Jung Vol.17)
18. Jung contra Freud: The 1912 New York Lectures on the Theory of Psychoanalysis (Bollingen Series (General))
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20. The Psychology of the Transference
21. Dreams: (From Volumes 4, 8, 12, and 16 of the Collected Works of C. G. Jung) (Jung Extracts)
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25. Two Essays on Analytical Psychology (Collected Works of C.G. Jung Vol.7)
26. The Symbolic Life: Miscellaneous Writings (The Collected Works of C. G. Jung, Volume 18)

***All the works are available at http://astore.amazon.com/freudandpsychoan?node=3&page=1**

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# Mental Retardation: Early Identification and Prevention

Mr. Mubashir Gull[1]

**ABSTRACT:**

Mental retardation is a serious intellectual disability. The diagnosis of Mental retardation in a child can trigger a range of emotional responses in parents & across the whole family. Parenting a child with a Mental retardation is a very difficult task as lot of stress, frustration, and hopelessness is experienced by them. The need of the study is to determine the early identification steps and preventive techniques of the mental retardation so that immediate steps would be taken by the parents to prevent and control the disability.

***Keywords:*** *Mental Retardation, Identification, Prevention*

Mental retardation (MR) refers to sub-average general intellectual functioning which originates during the development period of the child and is associated with impairment in adaptive behavior (Solanki et al. 2015). It is a genetic disorder manifested significantly below average overall intellectual functioning and deficits in adaptive behavior (Armates 2009). Mental retardation is characterised by impaired intellectual, adaptive functioning, and have an IQ less than 70 with difficulty in daily living activity (ADL). It is a condition of incomplete development of the mind, which is generally characterised by impairment of skills, and is manifested during the development period, which contributes to overall level of intelligence (ICD-10). The diagnosis of mental retardation in a child can trigger a range of emotional responses in parents & across family system. For some, it will constitute a crisis that requires extraordinary psychological adjustment from parents and contains elements of harm, loss and weakness. For others, the birth of a disabled child will be viewed as an unfortunate event; it may further provoke psychological growth in some family members. The initial parental response may be a form of emotional disintegration. This may evolve into a period of adjustment and later into reorganisation of the family's daily life (Marcia 1982). Mental deficiency and maladjustment has become an alarming universal problem in this existing society. Down syndrome and fragile X syndrome often overlap with mental retardation. It is an incomplete or arrested development of mind of a person, which is characterised by sub-normality of intelligence (PWD ACT 1994). Mental retardation is a sub-average intellectual functioning and limitation in adaptive skills such as communication, self-care, social skills, health, safety and work and is manifested before the age of 18 years (AAMR 1994, 2002).

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Mental retardation impediment in kids is frequently missed by clinicians. This condition may be as an isolated finding or as a part of a disorder, or more extensive issue (Daily, Ardinger & Holmes, 2000). Reasons for mental retardation are various and include hereditary as well as environmental elements. In at least 30 to 50 percent of cases, physicians fail to focus etiology regardless of in-depth assessment (Baird & Sadovnick, 1985). Diagnosis is highly dependent on a comprehensive personal and family medical history, a complete physical examination and a careful developmental assessment of the child. Aforementioned elements will guide suitable assessment and referrals to provide genetic counseling, resources for the family and early intervention programs for the youngsters (Rutter, 2006).

## CLASSIFICATION OF MENTAL RETARDATION

Based on the DSM-IV TR (2004) and AAMR (1983), the operational classification for persons with mental retardation is as follows.

| Levels of Retardation | DSM-IV-TR CLASSIFICATION | AAMR CLASSIFICATION |
|---|---|---|
| Mild Mental Retardation | 50-55 - 70 | 55 - 69 |
| Moderate Mental Retardation | 35-40 - 50-55 | 40 - 54 |
| Severe Mental Retardation | 20-25 - 35-40 | 25 - 39 |
| Profound Mental Retardation | Below 20 or 25 | 0 - 24 |

## EARLY IDENTIFICATION

The first and most important step in the diagnosis of mental retardation is to conduct study of a comprehensive patient and his family history. Previous gynecologic and obstetric history has revealed infertility or fetal loss as identification (Matson & Sevin, 1994). Assessment of maternal health status during pregnancy with the involved child should include questions regarding utilisation of tobacco, alcohol and drugs; lifestyle or other risks for sexually transmitted diseases; weight gain or loss; indications of contamination; serious illness or injury; and surgery or hospitalisation (Reiss, 1994; Szymanski, 1994). NIMH in 1998 developed a systematic method for identification and screening of mentally retarted children.

**(1) Prenatal procedure for identification of Mentally Retarted children**

- Blood tests should be carried out for detecting anemia, diabetes, syphilis and neural tube defects.
- Ultra Sonography should be carried out in the second trimester of the pregnancy for detecting certain disorders such as hydrocephaly, microcephaly, holoprocencephaly, prosencephaly and some cerebral lesions.
- Foetoscopy should be carried out during the second trimester of pregnancy for diagnosing physical anomalies, metabolic disorders or biochemical abnormalities.

(2) **Perinatal or Natal identification.**

- Peri-natal infections have long-term cognitive effects such as neonatal herpes simplex virus (HSV) and group B Streptococcus infection.

- HSV (Herpes Simplex Virus) often has a long term neurological impairment such as MR.
- Group B streptococcus has meningitis which may display neurosensory impairment, and is acquired in utero at the time of delivery or during the first 7 days of life.
- Low birth weight (< 2500 gm) and preterm delivery < 37 weeks is also associated with an increased risk of MR.
- LBW/PRE (Low birth weight or Preterm delivery) infants who were growth retarted at birth tend to have lower mean IQs than appropriate growth LBW/PRE (Sung et al. 1993).

**(3) Postnatal identification**

Post natal causes of mentally retarted are easily detectable than pre-natal and peri-natal causes.

- Exposure of the child to contaminated environment (such as lead, methyl- mercury, polychlorinated biphenyls etc.) can lead neurological damage.
- A severe accident which leads head injury can also impair cognition.
- NIMH Scenderabad in 1998 has developed quick screening schedule for identification of mental retardation in children

**NIMH Screening Schedule:**

| Stage No | Child's Progress | Normal Development | Delayed Development if not achieved by the period. |
|---|---|---|---|
| 01 | Respond to name/voice | 1-3 months | 4th month |
| 02 | Smile at others | 1-4 months | 6th month |
| 03 | Hold head steady | 2-6 months | 6th month |
| 04 | Sits without support | 5-10 months | 12th month |
| 05 | Stand without support | 9-14 months | 18th month |
| 06 | Walks well | 10-20 months | 20th month |
| 07 | Talks in 2-3 word sentences | 16-30 months | 3rd year |
| 08 | Eats/drinks by self | 2-3 years | 4th year |
| 09 | Tells his name | 2-3 years | 4th year |
| 10 | Has toilet control | 3-4 years | 4th year |
| 11 | Avoid simple hazards | 3-4 years | 4th year |
| **Other factors** | | | |
| 12 | Has fits | Yes | No |
| 13 | Has physical disability-what? | Yes | No |

| S. no | Name of instrument | Administration time | Age range | Author's Name |
|---|---|---|---|---|
| 01 | DST (Developmental Screening Test) | 10 min. | 1-15 years | J. Bharat Raj (1977.1978, 1983) |
| 02 | Gesell Drawing Test | 15 min. | 1-8 years | Verma, Dwarka & Kaushal (1972) |
| 03 | Vineland Social Maturity Scale | 15-20 min. | 0-15 years | Malin (1970) |

## PREVENTION

"Prevention is better than cure." The wisdom of this saying is that a little effort in the early stage of the problem would help us to solve the problem before it becomes too complicated. This principle is always observed by wise people who achieved success in their lives and those who fail to recognise this principle have to suffer even though they are intelligent and hard working. Based on the principle of early identification, the prevention of mental retardation is paramount. Prevention refers to the measures taken at the early stage to decimate the disability. Some of the early preventions techniques noted by Baraff et al.1993. Bushan et al. 1993., Stagno & Whitley 1985 are.

**(1) Prenatal preventions**.

- Avoid hard physical work such as heavy loads, climbing stools and chairs, walking on slippery grounds etc.
- Avoid unnecessary drugs and medication.
- Avoid smoking, consuming alcohol and chewing tobacco.
- Avoid sexual contact with the person having venereal disease.
- Take precautions against lead poisoning.
- All pregnant women should take tetanus injections.
- Regular medical checkup in case of swelling of feet, fever, difficulty in urinating, bleeding from vagina and yellowness of eyes.

**(2) Perinatal or Natal Preventions.**

- Delivery should take place in a hospital where all the facilities are available.
- If the baby didn't cry immediately after birth, resuscitation measures should be undertaken at once.
- Babies born with (> 2.5KG) may need Neonatal care.
- In case if the head of the baby is too small or too large physician should be consulted.
- Brest feeding should be started immediately after birth.

**(3) Postnatal Preventions.**

- Don't allow a child to have a contact with paint, lead, newsprint ink etc.
- Every child should be immunized against infectious disease.
- Precautions should be taken against head injury and accidents.
- Ensure that the child gets a well balanced diet and clean drinking water.
- Don't slap a child in the face. It may lead injury of the ear drum.

## CONCLUSION:

Mental retardation is a genetic disorder manifested significantly below average overall intellectual functioning and deficits in adaptive behavior. Various natural, hereditary or different elements can result in mental retardation. It is better to stop something bad from happening than to deal with it after it has happened. So before identification of the stressful situation like birth of a mentally retarted child in family, parents particularly mothers should prevent themselves from

alcohol, smoking and other toxic substances. They should avoid sexual contact with the person having venereal disease, unnecessary drugs and medication also. The base of the mental retardation either starts because of hereditary or from the mother's womb and then there is a little chance from accidents too.

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# Psychological Correlates of Contextual Performance at Work: An Empricial View

Dr. Chandrani Sen[1], Aditi kaul[2]

**ABSTRACT:**

In the present corporate scenario employees' need to look beyond their assigned duties at work and adopt a holistic approach .Competitive employee tends to exceed the required role demands and goes that extra mile in order to excel in their overall performance. Contextual performance refers to this discretionary behaviour which goes beyond the boundary of assigned duties and contributes to the overall functioning of the organization. Through this study, the researcher attempts to study the relationship between contextual performance and its psychological correlates i.e. work engagement, psychological empowerment and spirit at work. A sample of 80 corporate executives was considered for the purpose of the study. Through application of correlational analysis, the hypothesized positive relationship between contextual performance and all psychological correlates was found to be significant. Further, through regression analysis psychological empowerment was found to be the strongest predictor of contextual performance among all the psychological correlates under study.

***Keywords:*** *Contextual Performance, Empricial View*

Job performance as a multidimensional concept includes a wide array of employee' activities which are not restricted to the duties assigned but also include employees' discretionary behaviour which contributes to the overall success of the organization. Contextual performance as a construct has been originated with the intention of evaluating this social and psychological contribution of the employees' in the organization. Borman and Motowidlo (1986) defined contextual performance as "behaviours that shape the organizational, social and psychological context that serve as a catalyst for task activities and process. It includes activities which are not goal or task specific but make individuals, teams and organizations more successful and effective. It comprises of cooperative and helping behaviour of an employee including voluntary performance of extra role activities, enthusiasm and extra determination to complete assignments successfully. Employees with contextual performance behaviour defend organizations' goals and adhere to organizational policies.

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[2]Research Scholar, The IIS University, Jaipur

Contextual performance differs from task performance as the latter contributes to the technical core and involves work directed towards the production of goods and services i.e. job role and assigned task duties whereas the former provides support to the social and psychological environment wherein the assigned duties are performed. Also, another way to distinguish the two can be explained as job –specific behaviour are a result of certain skill set and knowledge which vary according to the job role whereas contextual behaviour relates more to the personality dimension of the individual and does not vary much across the working tenure of the individual. Moreover, when the employees find their job mundane and less meaningful, it is contextual behaviour comprising loyalty and persistence among other qualities that sets the tone and proves crucial for the overall performance of the organization.

There are various psychological factors that influence contextual performance of an employee. For an employee to think about the overall success of the organization and look beyond the task and duties assigned, a sense of attachment and feeling of oneness with the organization is of great importance. Also, feeling empowered and having a sense of control and belief in ones' ability gives courage and confidence to face challenges and take responsibility beyond the usual. This paper explores the relationship of contextual performance with its psychological correlates i.e. work engagement, spirit at work and psychological empowerment.

An engaged worker focuses on the work performed and willingly dedicates ones' self (physical, cognitive and emotional) to the work assigned. Kahn (1990) suggested that an engaged employee approaches work with a sense of self investment, passion and a lot of energy and it translates into not only high performance but high extra role behaviour as well. Engagement acts as an indicator of employee's willingness to expend discretionary effort to help the organization .Individuals who invest themselves completely in their work role are likely to carry a broader conception of the role assigned and probability of their stepping out of the formal boundaries of work assigned and facilitating the organization at large and people within is more (Rich et al, 2010).

Conger and Kanungo (1988) described empowerment as a process whereby conditions that foster powerlessness are identified and removed by providing efficacy information, thereby enhancing employees' self efficacy. Klagge (1998) recognized empowerment as an assigned responsibility and activity for the employees in order to attain their abilities for appropriate decisions at work. Individual spirit at work refers to the desire of employees to express all aspects of their being at work, to be engaged in meaningful work (Ashmos and Duchon, 2000) and to achieve their personal fulfillment through work. Kinjerski and Skrypnek (2004) stated that spirituality describes the experience of employees who are very passionate about their work and feel energized. They find meaning and purpose in their work and also feel connected to coworkers. As this construct covers beyond individual perspective and thinking, being spiritually aligned results in extra role behaviour and employees tend to go that extra mile and work beyond the assigned tasks and duties.

## HYPOTHESES

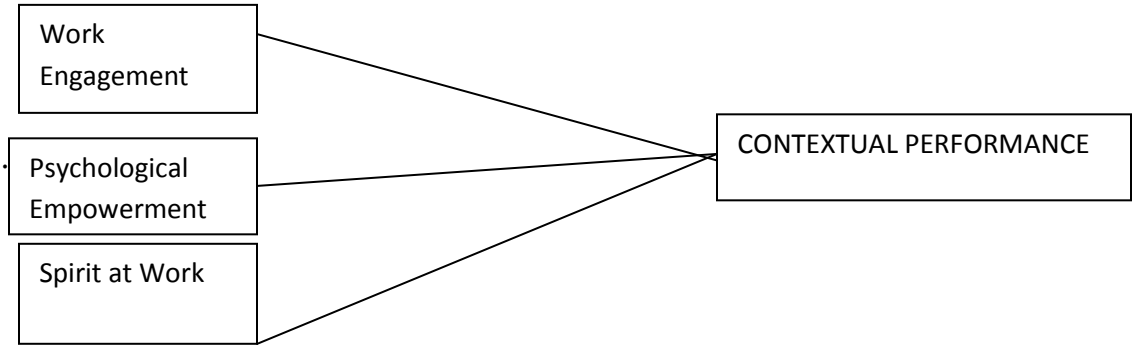
$H_1$ There will be a positive relationship between work engagement and contextual performance.

$H_2$ There will be a positive relationship between psychological empowerment and contextual performance.

$H_3$ There will be a positive relationship between spirit at work and contextual performance.

## RESEARCH DESIGN

A correlation framework was designed for the purpose of the study.




## SAMPLE

A sample of 80 corporate executives was undertaken for the purpose of the study. Criteria for inclusion comprised of employees in the middle level management with a minimum association of 3 years with the current organization. Part time and newly recruited employees were kept beyond the purview of the study. Data was analyzed through correlational analysis.

## INSTRUMENTS

Scales used for the purpose of the study included:

The Utrecht work engagement scale developed by Wilmar B. Schaufeli Arnold B. Bakker in 2002. The scale comprises of seventeen items to be rated on a seven-point Likert scale. Reliability of the scale was found to be ranging between 0.68 and 0.91.

The psychological empowerment scale developed by Spreitzer in 1995. The scale consists of 12 items which are to be rated on a six-point Likert scale. Reliability of the scale was found to be 0.80.

The Spirit at Work Scale (*SAWS*) developed by Kinjerski and Skrypnek in 2006. The scale comprises of eighteen items which are to be rated on a six-point Likert scale. Reliability of the scale was measured to be .93.

The contextual performance scale developed by Motowidlo and Van Scotter in 1994.The scale consists of 16-items which were rated on a five-point Likert scale.

## RESULT AND ANALYSES

**Table 1, Mean and Standard Deviation of Variables Under Study**

(N=80)

| VARIABLES | MEAN | SD |
|---|---|---|
| CONTEXTUAL PERFORMANCE | 65.93 | 10.9 |
| WORK ENGAGEMENT | 71.17 | 20.5 |
| PSYCHOLOGICAL EMPOWERMENT | 60.22 | 13.4 |
| SPIRIT AT WORK | 66.31 | 15.1 |

**Table 2, Correlational Matrix**

| VARIABLES | CONTEXTUAL PERFORMANCE |
|---|---|
| WORK ENGAGEMENT | .596** |
| PSYCHOLOGICAL EMPOWERMENT | .680** |
| SPIRIT AT WORK | .607** |

* Correlation is significant at the 0.05 level

** Correlation is significant at the 0.01 level

**Table 3, Regression Table, Model Summary**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .702(a) | .492 | .472 | 7.94409 |

a Predictors: (Constant), SW, PE, WE

**ANOVA(b)**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 4652.440 | 3 | 1550.813 | 24.574 | .000(a) |
| | Residual | 4796.247 | 76 | 63.109 | | |
| | Total | 9448.688 | 79 | | | |

a Predictors: (Constant), SW, PE, WE

b Dependent Variable: CP

**Coefficients(a)**

| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. |
|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | B | Std. Error |
| 1 | (Constant) | 29.037 | 4.609 | | 6.300 | .000 |
| | WE | -.026 | .094 | -.049 | -.275 | .784 |
| | PE | .424 | .110 | .521 | 3.871 | .000 |
| | SW | .199 | .112 | .276 | 1.777 | .079 |

a Dependent Variable: CP

## DISCUSSION

The present study was undertaken to investigate the relationship between Contextual performance and its psychological correlates i.e. psychological empowerment, spirit at work and work engagement. In order to examine the relationship between the variables and evaluate the results of the study a correlational framework was designed. Borman and Motowidlo (1993) defined contextual performance as behaviours that "do not support the technical core itself as much as they support the organizational, social and psychological environment in which the technical core must function". Contextual performance has become an important variable in the field of organizational psychology, both in research as well as applied settings (Borman & Motowidlo, *et al* 1997).

The first formulated hypothesis stated a positive relationship between contextual performance and work engagement. Analysis of data revealed a positive correlation of .596 between two variables. Result indicated the fact that engaged employees' exhibit high contextual performance. Researches for long have argued that engagement as a motivational construct

should lead to levels of job performance (Schaufeli *et al*, 2002, Rich *et al*, 2010). On similar lines, Christian *et al* (2011 ) in a meta –analytic study tested the role of engagement as a mediator between antecedents and job performance and found a direct effect between work engagement and job performance (task and contextual). Engagement relates strongly to contextual performance (Gorgeivski et al, 2009). Work engagement is the investment of multiple dimensions (physical, cognitive and emotional) and leads to a holistic experience at work. Therefore, employees who feel connected to their work tend to go that extra mile and perform duties beyond the tasks assigned.

The second hypothesis stated a positive relationship between psychological empowerment and contextual performance. A positive correlation of .680 was found between the two variables, thus supporting the formulated hypothesis. The results indicate the fact that employees who perceive a sense of control at work and feel psychologically empowered at work also tend to adopt a holistic approach and work beyond the task assigned. They showcase voluntary behaviour and work towards the overall development of the organization. Empowered individuals perform better than relatively less empowered individuals. Also, feeling of being empowered at work gives way to proactive behaviour such as resilience, persistence and flexibility (Thomas and Velthouse, 1990). In congruence with the stated hypothesis, Tuuli *et al* (2009) study revealed similar results through their study on performance consequences of psychological empowerment.

Spirit at work was found to be positively correlated to contextual performance. The above finding supported the third formulated hypothesis which stated a positive relationship between the two variables. The correlation value was found to be .607. Finding a higher purpose at work acts as a motivating factor for employees to look beyond the task roles and indulge in extra role behaviour.

For further investigation, regression analysis was conducted. Results of which revealed that 49.2 percent of the variance in the dependent variable i.e contextual performance is accounted for by all the independent variables under the study wherein, Psychological empowerment emerged as the strongest predictor of contextual performance among all the psychological correlates with a variance of 42.4 percent. This illustrates that empowered employee who perceives a sense of control and is confident about their abilities exhibit a stronger will to contribute to the social and psychological environment which supports the technical core work of the organization.

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# Grief, Traumatic Loss and Coping following Bereavement: Case Study of Women

Salma Kaneez[1]

**ABSTRACT:**

Loss of a loved one is a very painful and often a traumatic experience for most of the people. The burden of the loss can be carried over a life time or laid down. Grief is a profound and complex response for those who have been left behind. There found different gender reactions in grief and traumatic event. Women tend to experience more intense emotional reactions such as shock, denial, anger, depression that may linger on for quite some time, especially when they were widow and mother. Individuals grieve differently, yet coping with bereavement depends upon the personal characteristics, available support, coping mechanism, faith and self concept of sufferers. Using the case study approach, this article explores the grief, trauma (psychological response) and coping pattern among bereaved women while struggling with the loss. The cases of three Muslim women widowed during the last one year were analyzed. Findings highlight the importance of social support, religious or spiritual beliefs, traumatic growth in bereavement and coping with the loss of a family member.

***Keywords:*** *grief, trauma, bereavement, coping.*

Bereavement is a universal life experience individuals have to grapple with the loss of a loved one. The human loss is mostly carries immense psychological burden that can be carried over a life time or laid down. The sense of irrevocability makes death a stressful event that often gives way to emotional crisis for the bereaved. Spousal bereavement is considered one of the most devastating losses during the life course, which can lead to decreased well-being and functioning with the experience of multiple negative emotions including sadness, helplessness, anger (Dutton and Zisook, 2005) and depression (Segrist, 2008). Grief is the emotional response to loss, the complex amalgam of painful affects including sadness, anger, helplessness, guilt and despair (Raphael, 1984). Grief is therefore a normal reaction to loss and refers to the distress resulting from the bereavement. It is multidimensional with physical, behavioral and meaning component. It is characterized by a complex set of cognitive, emotional and social adjustment that follows the death of a loved one.

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Although people vary in the types of grief they express (Christ G. et al., 2003), most grieving people show similar patterns of intense distress, anxiety, yearning, sadness, preoccupation and these symptoms gradually settle overtime.

Working through grief is a painful process for most of the people. Results of previous researches show that patterns of adjustment to bereavement are influenced by various factors including spirituality (Bisconti et al., 2004). In addition, grief reactions appear to be stronger when coping mechanism are not appropriate for the loss, when the bereaved person does not receive adequate support (Macias et al., 2004) and widows show stronger grief reaction than men (Shear et al., 2006 and Neria et al., 2007). All bereavements are traumatic, but vary in outcomes. Partner's death among women in particular is the most traumatic loss, because it leads to a loss of identity resulting in increased level of emotional and social loneliness.

## OBJECTIVE:

The present study aimed to examine the perception of loss following bereavement, psychological reactions to loss (grief), and the coping resources the respondents (widows) used to deal with the conjugal loss.

## METHODOLOGY:

In the present study, the case study method was adopted for data collection. The participants were three recently bereaved (within 1 year of loss) Muslim widows with age range of 40 to 50 years. All were middle class women, non-working and literate (above 10 years of schooling). The instruments for data collection were the observation and semi-structured interview schedule. The schedule contained items pertaining to the initial reactions to death, view about death and dying, psychological responses, available support, coping resources and positive or negative part of their experience. Being a sensitive subject, the participants already acquainted with the researcher, were made agreed to share their experiences as part of the research to investigate into peoples' attitude to death and bereavement.

### *Case -1:*

A 40 years old widow with two young children lost her husband aged 48 due to severe liver infection within three months of diagnosis. Having a nuclear family and dependent status, it was a shock for her. Since the deceased was under regular doctor's advice, the family did not expect the loss so early. She said, *"We were hoping that he would soon be alright but he left us*. She could not foresee how to take care of her family and manage all things. She said, *"I was so hopeless and distressed that I could not comprehend what to do*?" Symptoms of sadness, difficulty in falling asleep, helplessness and disbelief were the initial responses to death. She told that relatives and friends took every responsibility of the last journey of the deceased. She was thankful to her parents and relatives who counseled her to play dual role for the sake of her children. She was made to realize that her children were disturbed, as they became irregular to school and studies. Faith in God and asking His help to resolve the crisis was her submission.

She revealed, *"It is very difficult ..... but we are alive to keep his (deceased) memory in our heart forever."* Fulfilling husband's dream seemed the only reason to stay back into life.

***Case -2:***

A 57 years old government employee died of cancer diagnosed three months before. It was a traumatic loss for the 45 years old widow and three dependent children (above 14 years of age). Medical care for cancer patient itself added financial burden to the family. Death of the head of the family resulted in sadness, depression, uncertainty, helplessness, anxiety followed by financial woes and blame on doctors. Their strong spiritual and religious belief helped them while confronting and accepting the loss due to death. They had poor social support and connection. Hence, psychological difficulties got linger on before their taking refuge into religion for final solace. She exclaimed with sorrow, *"Only God has to rescue us."* The gradual decline in their sufferings was possible through their belief in God and hope that elder son aged 20 years would take over the charge of family responsibilities.

***Case -3***:

A woman aged 47 years with her five children was traumatized upon the sudden death of her husband, 52 years (Government employee) due to heart attack. The acceptance of death was very difficult. The sudden departure of loving and caring man led to the feeling of anger, numbness, disbelief, anxiety among family members. Question of survival, role change, financial uncertainty and marriage prospects of daughters were the harsh realities she visualized. She said with certainty, "*it was like a darkness, but Allah will save us."* It took longer time to recover from the loss before they learned to calm down. The support of family acquaintances and kin relationship were quite helpful in healing. Being a Muslim, acceptance of God's will and finding support through prayers were the important resources. The family worked through the grief that finally subdued when the elder son came forward to shoulder the responsibilities in the absence of his father.

Interpretative analysis of the above cases brings into focus the following three main themes;

**(a) Grief and Women :**

Death of a loved one always poses problems in recovering from the loss. There found different reactions by the bereaved depending upon the nature and circumstances of death, relationship with the deceased and personal characteristics. The sudden death with little or no preparation results in more abrupt and difficult grieving process. Besides the normal grief in loss, the suddenness and untimely (unexpected) death carry extra burden of shock and the sense of being broken and overwhelmed. There is no opportunity to anticipate and for getting through the loss and resultant grief. For example in Case-3, the respondent lost her husband during the very first heart attack. It was a traumatic event for the entire family over gripped by severe emotional conditions such as shock, denial, numbness, yearning persisted for quite some time. Initially, it was hard to believe dying and death but gradually they learned to live without the deceased.

Given the Indian social milieu, death of a spouse is very traumatic for a woman in the sense a long relationship comes to an end. The emotional feelings in response to death sometimes intensified by the anticipated financial worries, if the deceased happened to be the only bread-winner. As common in all three cases, the post-death scenario necessitated a major social adjustment for the surviving spouse to parent alone, face single life and find some alternative employment or source of income.

(b**) Bereavement and Social Support**:

The most important factor in healing from loss is enlisting the support of the people. While dealing with death, the support bereaved received is crucial because it affects their ability to cope and recover from the personal trauma. It is natural to vent the feelings while grieving, as sharing the loss makes the burden of grief easier to carry. Indian collectivistic culture and traditions fortunately created a dominant atmosphere of sharing and cooperation in the midst of bereavement (death). The involvement of religious community is beneficial while negotiating with the loss. The bereavement is not limited to the immediate family, rather it impacts the whole social framework. In all our cases, the bereaved individuals got and utilized available support as the coping resource to tackle pain and suffering in loss. Researches suggest that family/ social support is instrumental in understanding and handling bereavement and associated grief as an inseparable part of human experience. Respondents viewed that social visits by the family people and friends brought a sense of relief and togetherness. Therefore, sharing time and talking with bereaved sympathetically were significant elements for social environment congenial in grieving and healing process.

**(c) Religion/ Spirituality and Bereavement:**

The beliefs and practices that stems from cultural–religious worldview reflects how people respond to bereavement. Religion and spirituality are significant constructs associated with bereavement that may act as buffers to declining physical and mental health status (Richardson, 2007). Spiritual and religious perspectives provide many resources for understanding and coping with loss. In the context of death, Muslims, for instance, consider acceptance of fate, belief in its being and expression of God's will as the basic tenant in Islam. Prolong public expression of grief and ritualized morning are discouraged in Islamic practice which places great value on the acceptance of God's (Allah's) will with restraint and understanding (Rubin & Yasein-Ismael, 2004). The religious faith provides guidance to people about coping with loss, teaching spiritual beliefs and perception that treat death as another life transition within the life cycle of an individual. All participants in our study have faith in their religion and asked God's help to deal with the crisis, as evident from their statements. The first respondent expressed thus, *"It is very difficult to live with the loss, but Allah helps me and gave me courage and strength to face the reality. Whenever I feel depressed or anxious I recite Quran and pray God to forgive my husband and place his soul in peace."* In Case-2, the widow described her state in similar words, *"I pray Allah to shower mercy on my husband and children. Life and death are pre-determined by Him. We have only to follow.* Respondent-3 told, "*Now we have learned to live without him.*

*Perhaps it was Allah's will. When I felt depressed and helpless, I asked Him to help me. It is none but Allah who will give us strength to carry on the task left by my husband. I used to recite Quran, pray God to forgive us and do charity regularly to restore harmony in the life after death."* The subjective responses of the participants revealed that the religious beliefs influence the process of coping with bereavement. Through the use of cognitive assimilation strategies, positive coping comes into play as the individual attempts to frame that loss within a pre-existing religious and spiritual schemas (Michael et al., 2003; Pargament, 1997). The finding is consistent with the previous research that found spirituality to have a positive impact on managing bereavement process and a belief in after life can generate a greater acceptance of death of a spouse (Dezulter et al., 2009; Walsh et al., 2002).

Participants spoke of a number of rituals or religious- spiritual practices (prayer, reciting Quran, charity) which facilitated emotional processing, reinforcing their sense of identity, relationships and social engagements. All religious traditions prescribe specific prayers, behaviors and funeral ceremonies to deal with death, which comfort mourners and give them a sense of belonging to a broader community (Wuthnow et al., 1980). Through these resources, individuals may find solace and comfort and over time, working through their grief in ways that allow them to find peace and acceptance and to return to their normal daily lives (Halifax, 2008). Religious / spiritual beliefs help sufferers to find meaning for the life and death of their deceased. One respond told, *"It was unbelievable to live without my husband, but God did what was good for him."* Another respondent stated, *"He was in tremendous pain, now Allah has freed him of all pains."* Of course normal life is forever changed after the loss of spouse, but it created better understanding with life, death, and new situations among the widowed

## CONCLUSION:

In sum, spousal bereavement is the most traumatic life cycle event for women and those left behind, often resulting in major social, psychological and spiritual transitions. It disturbs the vital functions within the family such as parenting functions including emotional nurturing, education and protection. Acceptance of a loss of loved one requires time and shift in cognitive and emotional approach to living. Social support is essential to successful grief reconciliation. Among the coping strategies utilized by the bereaved, religious coping is recognized as the most valuable resource. Religious coping enhances a person's psychological resource, e.g., sense of mastery and self esteem and help the individual to build an interpretative frame work (Siegel, et al, 2001) or cognitive schema (e.g., search for and finding meaning).Acceptance of fate and belief being the expression of God's will as enshrined in Islam, were commonly invoked by the Muslim widows. In the loss, the ultimate focus remained on the relationship with God. In fact the connectedness with God, religion and community of believers serve to heal the sense of loneliness and bereftness (acute emotional deprivation) that the widow feels so acutely. The relationship with God helps to provide support and strength, reduces loss of control and helplessness. Moreover, religious beliefs and practices provide a cognitive framework that can decrease suffering and strengthen one's purpose and meaning in the face of trauma (Pargament,

1997). Hence, bereaved seeks control through a partnership with God, asks God's forgiveness for himself and deceased. The findings underline the need to develop counseling techniques and infrastructure where the social support is lacking. In contrast to man, women allowed greater latitude in expressing emotional turmoil during significant loss. They are more defined by relationships which prohibit them to return to their normal functioning quickly. It is therefore recommended that women may be encouraged to equip themselves with the skill oriented education and training to meet economic uncertainties consequent to the spousal death.

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# Investigation of Schema Therapy Performance in Borderline Personality Disorder Patients

Elham Mohammadipour[1]

*This Article has remove from this issue. Because, this article under the copyright issue and plagiarism.

** This article has been retracted at the request of the Editor-in-Chief.

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# Emotional Disturbances and Child Sexual Abuse: A Psychosocial Perspective

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**ABSTRACT:**

Child abuse has many forms: physical, emotional, sexual, neglect, and exploitation. Any of these that are potentially or actually harmful to a child's health, survival, dignity and development are abuse. Violence against children can be "physical and mental abuse and injury, neglect or negligent treatment, exploitation and sexual abuse". Research conducted over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused children than among individuals with no such experiences. This article summarizes what is currently known about these potential impacts of child sexual abuse. Various problems and symptoms described in the literature on child sexual abuse are reviewed in a series of broad categories including; Child sexual abuse, variety of sexual offenses, indications of sexual abuse in children and adolescents in terms of emotional and behavioural signs. In conclusion importance of psychotherapies have been mentioned as psychological intervention and was discussed few laws against child sexual abuse in the United States and India.

***Keywords:*** *Child, emotional disturbances, psychosocial perspectives, sexual abuses*

Violence against children can be "physical and mental abuse and injury, neglect or negligent treatment, exploitation and sexual abuse. Violence may take place in homes, schools, orphanages, residential care facilities, on the streets, in the workplace, in prisons and in places of detention". Such violence can affect the normal development of a child impairing their mental, physical and social being. In extreme cases abuse of a child can result in death. Child abuse has many forms: physical, emotional, sexual, neglect, and exploitation.

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Any of these that are potentially or actually harmful to a child's health, survival, dignity and development are abuse. Physical abuse is when a child has been physically harmed due to some interaction or lack of interaction by another person, which could have been prevented by any person in a position of responsibility, trust or power. Emotional abuse can be seen as a failure to provide a supportive environment and primary attachment figure for a child so that they may develop a full and healthy range of emotional abilities. Emotional abuse is also the act of causing harm to a child's development, when they could have been within reasonable control of a person responsible for the child. Examples of these acts are restricting movement, threatening, scaring, discriminating, ridiculing, belittling, etc. A rising concern is the pressure, children feel to perform well in school and college examinations, which can be seen as a form of emotional stress and abuse. Sexual abuse is engaging a child in any sexual activity that he/she does not understand or cannot give informed consent for or is not physically, mentally or emotionally prepared for. Abuse can be conducted by an adult or another child who is developmentally superior to the victim. This includes using a child for pornography, sexual materials, prostitution and unlawful sexual practices. Neglect or negligent treatment is purposeful omission of some or all developmental needs of the child by a caregiver with the intention of harming the child. This includes the failure of protecting the child from a harmful situation or environment when feasible.

**Child sexual abuse** or **child molestation** is a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation (Child Sexual Abuse [CSA], 2008; APA Board of Professional Affairs", 1999). Forms of child sexual abuse include asking or pressuring a child to engage in sexual activities (regardless of the outcome), indecent exposure (of the genitals, female nipples, etc.) to a child with intent to gratify their own sexual desires or to intimidate or groom the child, physical sexual contact with a child, or using a child to produce child pornography ("CSA", 2014; Martin, Anderson, Romans, Mullen., & O'Shea, 1993).

**Child sexual abuse includes a variety of sexual offenses**

a) *Sexual assault* – a term defining offenses in which an adult uses a minor for the purpose of sexual gratification; for example, rape (including sodomy), and sexual penetration with an object (Finkelhor, David, Ormrod & Richard, 2001).

b) *Sexual exploitation* – a term defining offenses in which an adult victimizes a minor for advancement, sexual gratification, or profit; for example, prostituting a child and creating or trafficking in child pornography (Finkelhor, David, Ormrod., & Richard, 2004).

c) *Sexual grooming* – defines the social conduct of a potential child sex offender who seeks to make a minor more accepting of their advances, for example in an online chat room.

d) *Incest* - A child sexual abuse offense where the perpetrator is related to the child, either by blood or marriage, is a form of incest described as intrafamilial child sexual abuse (Fridell,

1990). Incest between a child or adolescent and a related adult has been identified as the most widespread form of child sexual abuse with a huge capacity for damage to a child. It is also known as child incestuous abuse (Courtois & Christine, 1988). When a prepubescent child is sexually abused by one or more other children or adolescent youths, and no adult are directly involved, it is defined as child-on-child sexual abuse. The definition includes any sexual activity between children that occurs without consent, without equality, or due to coercion (Shaw et al., 2000) whether the offender uses physical force, threats, trickery or emotional manipulation to compel cooperation. When sexual abuse is perpetrated by one sibling upon another, it is known as "intersibling abuse", a form of incest (Caffaro & Conn-Caffaro, 2005). Unlike research on adult offenders, a strong causal relationship has been established between child and adolescent offenders and these offenders' own prior victimization, by either adults or other children (Bromberg, Johnson., & Blair, 2001).

e) The term *pedophilia* refers to persistent sexual feelings of attraction in an adult or older adolescent toward prepubescent children, whether the attraction is acted upon or not. A person with this attraction is called a pedophile.

f) *Commercial sexual exploitation of children (CSEC***)** is defined by the Declaration of the First World Congress against Commercial Sexual Exploitation of Children, held in Stockholm in 1996, as "sexual abuse by an adult accompanied by remuneration in cash or in kind to the child or third person(s). CSEC usually takes the form of child prostitution or child pornography, and is often facilitated by child sex tourism. CSEC is particularly a problem in developing countries of Asia. In recent years, new innovations in technology have facilitated the trade of Internet child pornography (UNICEF, 2006).

g) *Child marriage* is one of the main forms of child sexual abuse; UNICEF has stated that child marriage "represents perhaps the most prevalent form of sexual abuse and exploitation of girls" (UNICEF, 2006).

h) Even seemingly less serious sexual behaviors are damaging to children and are considered abusive. For instance:-fondling or kissing a child in a sexual manner, making a child watch pornographic movies or observe sexual activities, exhibiting one's sexual organs to a child or making the child display his or her own genitals, taking sexually explicit photographs of a child, talking with a child in a sexual or seductive manner.

## INCIDENCE AND PREVALENCE

Child sexual abuse can occur in a variety of settings, including home, school, or work (in places where child labor is common). Up to two-thirds of females and one-third of males may be sexually abused at some time in their lives. Sexual abuse is present in all classes, races and religions. Females are two to three times more likely than males to be sexually abused.

The global prevalence of child sexual abuse has been estimated at 19.7% for females and 7.9% for males, according to a 2009 study published in *Clinical Psychology Review* that examined 65 studies from 22 countries. Using the available data, the highest prevalence rate of child sexual abuse geographically was found in Africa (34.4%), primarily because of high rates in South Africa; Europe showed the lowest prevalence rate (9.2%); America and Asia had prevalence rates between 10.1% and 23.9%("Prevalence of Child Sexual Abuse in Community and Student Samples: A Meta-Analysis").

Most sexual abuse offenders are acquainted with their victims; approximately 30% are relatives of the child, most often brothers, fathers, uncles or cousins; around 60% are other acquaintances, such as "friends" of the family, babysitters, or neighbors; strangers are the offenders in approximately 10% of child sexual abuse cases (Julia, 2007). Most child sexual abuse is committed by men; studies show that women commit 14% to 40% of offenses reported against boys and 6% of offenses reported against girls (Julia, 2007).

The most-often reported form of incest is father–daughter and stepfather–daughter incest, with most of the remaining reports consisting of mother/stepmother–daughter/son incest (Turner, 1996). Father–son incest is reported less often; however it is not known if the actual prevalence is less or it is under-reported by a greater margin (Meyer & Michel, 2002). Similarly, some argue that sibling incest may be as common, or more common, than other types of incest: Goldman and Goldman (Goldman & Padayachi, 1997) reported that 57% of incest involved siblings; Finkelhor reported that over 90% of nuclear family incest involved siblings (Finkelhor, 1979) while Cawson, Wattam and Brooker, (2000) show that sibling incest was reported twice as often as incest perpetrated by fathers/stepfather.

In 2007 the Ministry of Women and Child Development published the "Study on Child Abuse: India, (2007) main findings of these study included 53.22% of children reported having faced sexual abuse". Among them 52.94% were boys and 47.06% girls. Andhra Pradesh, Assam, Bihar and Delhi reported the highest percentage of sexual abuse among both boys and girls, as well as the highest incidence of sexual assaults. 21.90% of child respondents faced severe forms of sexual abuse, 5.69% had been sexually assaulted and 50.76% reported other forms of sexual abuse. Significant underreporting of sexual abuse of boys by both women and men is believed to occur due to sex stereotyping, social denial, the minimization of male victimization, and the relative lack of research on sexual abuse of boys (Watkins & Bentovim, 1992).

***Types of offenders****:* Early research in the 1970s and 1980s began to classify offenders based on their motivations and traits. Groth and Birnbaum (1978) categorized child sexual offenders into two groups, "fixated" and "regressed". Fixated were described as having a primary attraction to children, whereas regressed had largely maintained relationships with other adults, and were even married. This study also showed that adult sexual orientation was not related to the sex of the victim targeted, e.g. men who molested boys often had adult relationships with women.

Holmes and Stephen (2002) expanded on the types of offenders and their psychological profiles. They are divided as follows.

I. Situational – does not prefer children, but offend under certain conditions.

- *Regressed* – Typically has relationships with adults, but a stressor causes them to seek children as a substitute
- *Morally Indiscriminate* – All-around sexual deviant, who may commit other sexual offenses unrelated to children.
- *Naive/Inadequate* – Often mentally disabled in some way, finds children less threatening.

II. Preferential – has true sexual interest in children.

- *Mysoped* – Sadistic and violent, target strangers more often than acquaintances.
- *Fixated* – Little or no activity with own age, described as an "overgrown child."

## INDICATIONS OF SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

### *1) Behavioral Signs*

- Sexualized behavior, for instance, children engaging in sexual play with dolls, or adolescents engaging in indiscriminate sexual activity
- Acting-out behaviors such as running away or temper tantrums
- Regressive behaviors such as thumb sucking, baby talk or curling up in fetal position
- Poor school performance
- Drug and/or alcohol abuse
- Self-mutilating behaviors, cutting self or hurting self in other ways
- Radical behavior change in any direction. For example, suddenly becoming a model child or suddenly beginning to act rebellious or unruly
- Eating disturbances
- Sleep disturbances, especially nightmares or insomnia
- Difficulty concentrating

### *2) Emotional Signs*

- Depressed or sad mood
- Feeling anxious in general or having fears of specific settings or circumstances, often related to the abusive situation
- Perfectionism
- Aggression
- Withdrawal
- Low self-esteem
- Guilt, self-blame

### *3) Physical Signs*

- Abdominal pain
- Genital, urethral or rectal pain, bleeding or abrasions
- Sexually transmitted diseases
- Recurrent urinary tract infections
- Bed-wetting

- Bed-soiling
- Pregnancy

## EMOTIONAL DISTURBANCES DUE TO SEXUAL ABUSE ON CHILDREN

Child sexual abuse can result in both short-term and long-term harm, including psychopathology in later life (Dinwiddie, Heath, & Dunne, 2000, Nelson, Heath, & Madden, 2002). A study funded by the USA National Institute of Drug Abuse found that "Among more than 1,400 adult females, childhood sexual abuse was associated with increased likelihood of drug dependence, alcohol dependence, and psychiatric disorders". A well-documented, long-term negative effect is the repeated or additional victimization in adolescence and adulthood (Messman-Moore., & Long, 2000). A causal relationship has been found between childhood sexual abuse and various adult psychopathologies, including crime and suicide (Julia, 2007; Freyd, Putnam., & Lyon, 2005) in addition to alcoholism and drug abuse (Zickler & Patrick, 2002). Males who were sexually abused as children more frequently appear in the criminal justice system than in a clinical mental health setting. Intergenerational effects have been noted, with the children of victims of child sexual abuse exhibiting more conduct problems, peer problems, and emotional problems than their peers (Roberts, o'Connor, Dunn, & Golding, 2004). The social stigma of child sexual abuse may compound the psychological harm to children (Holguin, Hansen, & David, 2003) and adverse outcomes are less likely for abused children who have supportive family environments (Romans, Martin, Anderson, O'Shea., & Mullen, 1995).

Indicators and effects include depression, somatization (Widom DuMont, Czaja, 2007; Arnow, 2004), anxiety, (Levitan, Rector, Sheldon., & Goering, 2003), eating disorders, poor self-esteem (Walsh., & DiLillo, 2011), sleep disturbances (Steine & Krystal, 2012), and dissociative and anxiety disorders including post-traumatic stress disorder (Arehart-Treichel., & Joan, 2005). Victims may withdraw from school and social activities and exhibit various learning and behavioural problems including cruelty to animals (Ascione, Friedrich, William, Heath, Hayashi., & Kentaro, 2003; Ascione & Frank, 2005) attention deficit/hyperactivity disorder (ADHD), conduct disorder, and oppositional defiant disorder (ODD) (Walsh & DiLillo, 2011). Teenage pregnancy and risky sexual behaviors may appear in adolescence (Tyler, 2002). Child sexual abuse victims report almost four times as many incidences of self-inflicted harm (Noll, 2003).

***Dissociation and posttraumatic stress disorder (PTSD):*** Child abuse, including sexual abuse, especially chronic abuse starting at early ages, has been found to be related to the development of high levels of dissociative symptoms, which includes amnesia for abuse memories (Chu, Frey, Ganzel., & Matthews,1999).When severe sexual abuse (penetration, several perpetrators, lasting more than one year) had occurred, dissociative symptoms were even more prominent (Draijer & Langeland,1999). Besides dissociative identity disorder (DID) and posttraumatic stress disorder (PTSD), child sexual abuse survivors may present borderline personality disorder (BPD) and eating disorders such as bulimia nervosa (Hornor, 2010)

***Neurological damage:*** Research has shown that traumatic stress, including stress caused by sexual abuse, causes notable changes in brain functioning and development (Maia, Perry & Bruce, 2006).Various studies have suggested that severe child sexual abuse may have a deleterious effect on brain development. Ito, Teicher, Glod., and Ackerman (1998) found "reversed hemispheric asymmetry and greater left hemisphere coherence in abused subjects;" (Ito et al.,1993) found that an increased likelihood of "ictal temporal lobe epilepsy-like symptoms" in abused subjects. Anderson et al. (2002) recorded abnormal transverse relaxation time in the cerebellar vermis of adults sexually abused in childhood. Teicher et al. (1993) found that child sexual abuse was associated with a reduced corpus callosum area; various studies have found an association of reduced volume of the left hippocampus with child sexual abuse and Ito et al. (1993) found increased electrophysiological abnormalities in sexually abused children. Some studies indicate that sexual or physical abuse in children can lead to the over excitation of an undeveloped limbic system, Teicher, (2002); Teicher et al. (1993) used the "Limbic System Checklist-33" to measure ictal temporal lobe epilepsy-like symptoms in 253 adults. Reports of child sexual abuse were associated with a 49% increase to LSCL-33 scores, 11% higher than the associated increase of self-reported physical abuse. Reports of both physical and sexual abuse were associated with a 113% increase. Male and female victims were similarly affected (Arehart-Treichel., & Joan, 2001).

Navalta et al. (2006) found that the self-reported math Scholastic Aptitude Test scores of their sample of women with a history of repeated child sexual abuse were significantly lower than the self-reported math SAT scores of their non-abused sample. Because the abused subjects verbal SAT scores were high, they hypothesized that the low math SAT scores could "stem from a defect in hemispheric integration." They also found a strong association between short term memory impairments for all categories tested (verbal, visual, and global) and the duration of the abuse (Navalta Polcari, Webster, Boghossian., & Teicher, 2006).

## PHYSICAL EFFECTS

***Injury:*** Depending on the age and size of the child, and the degree of force used, child sexual abuse may cause internal lacerations and bleeding. In severe cases, damage to internal organs may occur, which, in some cases, may cause death (Anderson et al. 2004).

***Infections:*** Child sexual abuse may cause infections and sexually transmitted diseases (De Jong, 1985). Depending on the age of the child, due to a lack of sufficient vaginal fluid, chances of infections are higher. Vaginitis has also been reported (De Jong, 1985).

***Treatment:*** The initial approach to treating a person who has been a victim of sexual abuse is dependent upon several important factors: age at the time of presentation, circumstances of presentation for treatment and co-morbid conditions. The goal of treatment is not only to treat current mental health issues, but to prevent future ones.

Children often present for treatment in one of several circumstances, including criminal investigations, custody battles, problematic behaviors, and referrals from child welfare agencies (Cynthia, Anthony., & Urquiza, 2004). The three major modalities for therapy with children and teenagers are family therapy, group therapy, and individual therapy, which course is used depends on a variety of factors that must be assessed on a case by case basis. For instance, treatment of young children generally requires strong parental involvement and can benefit from family therapy. Adolescents tend to be more independent; they can benefit from individual or group therapy. The modality also shifts during the course of treatment, for example group therapy is rarely used in the initial stages, as the subject matter is very personal and/or embarrassing (Cynthia, Anthony., & Urquiza, 2004).

Major factors that affect both the pathology and response to treatment include the type and severity of the sexual act, its frequency, the age at which it occurred, and the child's family of origin. Roland C. Summit, a medical doctor, defined the different stages the victims of child sexual abuse go through, called *Child Sexual Abuse Accommodation Syndrome*. He suggested that children who are victims of sexual abuse display a range of symptoms that include secrecy, helplessness, entrapment, accommodation, delayed and conflicted disclosure and recantation (Summit, 1983).

## PSYCHOLOGICAL INTERVENTIONS

Psychotherapy as psychological intervention can be delivered from a broad range of theoretical perspectives, including, behavioural/ cognitive, existential/humanistic, gestalt, interpersonal, psychoanalytic/ psychodynamic, Rogerian/ person-centred and systemic. Therapists typically employ one of these guiding theories, though integrative approaches, which aim to multiply the benefits of different approaches, are becoming more common (Allnock et al., 2009). Some of the more common integrative approaches within sexual abuse services for children are CBT, eye movement desensitisation and reprocessing, and transactional analysis (Prochaska, 1999).

***Disclosure:*** Children who received supportive responses following disclosure had less traumatic symptoms and were abused for a shorter period of time than children who did not receive support (Gries et al., 2000; Kogan, 2005). In general, studies have found that children need support and stress-reducing resources after disclosure of sexual abuse (Palmer, Brown, Rae-Grant, & Loughlin, 1999). Negative social reactions to disclosure have been found to be harmful to the survivor's well being (Ullman, 2003).One study reported that children who received a bad reaction from the first person they told, especially if the person was a close family member, had worse scores as adults on general trauma symptoms, post traumatic stress disorder symptoms, and dissociation (Roesler, 1994). Another study found that in most cases when children did disclose abuse, the person they talked to did not respond effectively, blamed or rejected the child, and took little or no action to stop the abuse (Palmer, Brown, Rae-Grant, & Loughlin, 1999). Non-validating and otherwise non-supportive responses to disclosure by the child's primary attachment figure may indicate a relational disturbance predating the sexual abuse that may have

been a risk factor for the abuse, and which can remain a risk factor for its psychological consequences (Schechter, Brunelli, Cunningham, Brown., & Baca, 2002).

The American Academy of Child and Adolescent Psychiatry provides guidelines for what to say to the victim and what to do following the disclosure ("Responding to Child Sexual Abuse). Asa Don (2008) has indicated that a minimization of the trauma and its effects is commonly injected into the picture by parental caregivers to shelter and calm the child. It has been commonly assumed that focusing on children's issues too long will negatively impact their recovery. Therefore, the parental caregiver teaches the child to mask his or her issues.

***Few Laws against child sexual abuse****:* They vary by country based on the local definition of who is a child and what constitutes child sexual abuse. Most countries in the world employ some form of age of consent, with sexual contact with an underage person being criminally penalized. As the age of consent to sexual behaviour varies from country to country, so too do definitions of child sexual abuse (Overview of the nature and extent of child sexual abuse in Europe).

Child sexual abuse is outlawed nearly everywhere in the world, generally with severe criminal penalties, including in some jurisdictions, life imprisonment or capital punishment (Levesque & Roger, 1999; "United Nations Convention on the Rights of the Child", 1989). An adult's sexual intercourse with a child below the legal age of consent is defined as statutory rape, based on the principle that a child is not capable of consent and that any apparent consent by a child is not considered to be legal consent.

The United Nations Convention on the Rights of the Child (CRC) is an international treaty that legally obliges states to protect children's rights. Articles 34 and 35 of the CRC require states to protect children from all forms of sexual exploitation and sexual abuse. This includes outlawing the coercion of a child to perform sexual activity, the prostitution of children, and the exploitation of children in creating pornography. States are also required to prevent the abduction, sale, or trafficking of children. As of November 2008, 193 countries are bound by the CRC, including every member of the United Nations except the United States and Somalia (Child Rights Information Network, 2008; Amnesty International USA, 2007).

***In the United States****:* Child sexual abuse has been recognized specifically as a type of child maltreatment in U.S. federal law since the initial Congressional hearings on child abuse in 1973(Child Abuse Prevention and Treatment Act of 1974, 2003 ).Child sexual abuse is illegal in every state(State Statutes - Child Abuse and Neglect), as well as under federal law (*Index of Child Welfare Laws,).*Among the states, the specifics of child sexual abuse laws vary, but certain features of these laws are common to all states (*Definitions of Child Abuse and Neglect, Summary of State Laws).*

***In India:*** The Protection of Children Against Sexual Offences Act, 2012 regarding child sexual abuse has been passed by the both the houses of the Indian Parliament in May 2012("Parliament

passes bill to protect children from sexual abuse". NDTV, 2012). The Act came into force from 14 November 2012 ("Tough law on sexual offences against children comes into force", 2013).

## PLAN OF ACTION

**A**ll children deserve childhoods free from all manner of sexual abuse and exploitation. Without this safety, we put our future as a society at risk. Fortunately, when we focus on innovative programming and policies, such as those presented in this plan of action, we lay the foundation for children's healthy growth and development into adults capable of having healthy relationships and thus reduce the potential for child sexual abuse and exploitation. Such as decrease the risk of future perpetration of child sexual abuse and exploitation; increase the engagement of effective bystander actions that can aid in the prevention of child sexual abuse and exploitation; promote norms that support healthy behaviours, images, and messages; promote environments and education that support healthy development, relationships, and sexuality; collaborate with media, businesses, and policymakers to develop and implement strategies to prevent child sexual abuse and exploitation; promote safe, stable, nurturing relationships for children in their homes and broader environments to decrease future risk of sexual abuse perpetration. Further, child sexual abuse and the normalization of such abuse and exploitation for individual or commercial gain, will be socially, economically, politically, and spiritually unacceptable in all of our communities.

## CONCLUSION

Research and clinical observation have long suggested that child sexual abuse is associated with both initial and long-term alterations in social functioning. Hence, prevention on multiple levels is the key to the protection of children. Victims of child sexual abuse suffer not only an intolerable violation of their right to physical integrity but also life-long horrific social, emotional and psychological consequences. Preventive measures should be holistic, child-centred and happen as early as possible with a minimum level of intervention.

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# A Study of Well-Being among Hindu and Muslim Students in Aligarh

Mohd. Ahamar Khan[1]

**ABSTRACT:**

The aim of this study was to measure different dimensions of well-being namely; physical, mental, social, emotional and spiritual, with respect to find out the difference between Hindu and Muslim students. The sample consisted of N=96(n=47 Hindu and n=49 Muslim students) participants. Well-Being Scale prepared by Singh and Gupta (2001) was used to collect the data. The Mean, SD and t-test were used for data analyses. The findings of this study revealed that, students significantly differ with each other on physical, social, and spiritual well-being dimensions. While, there was no significant difference was found on mental and emotional well-being dimensions between Hindu and Muslim students. Results also showed Muslim students have higher mean score on each dimensions of well-being than the Hindu counterparts.

***Keywords:*** *Well-being, Hindu and Muslim Students.*

The concept of well-being refers to individual's fullest functioning in everyday life. World Health Organization (World Health Organisation, 1952) argued optimal health as "a state of complete physical mental and social well-being and not merely the absence of disease or infirmity." They also summed spiritual well- being as one dimension of well-being. Shaffer and Shoben ( 1956) defined well-being as: (1) good physical well- being; (2) accepting one's strengths and weakness; (3) accepting other people; (4) seeking as well as having a warm feeling towards them; (5) a confidential relationship; (6) active attention; (7) social participation; (8) satisfying work; (9) creative experience; (10) using the scientific method. Scheidt (1986) conducted the study on 989 residents of small towns and found that those subjects who experienced high subjective well-being generally expressed satisfaction with living conditions social relations, and functional health**.**

Bower (1961) defined mental well-being as 'it is one of the degree of freedom in which an individual has to think alternatives available to deal with the stresses and strains of living.' From this point of view those people who have high mental well-being, they easily deal psychological distresses in everyday lives.

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Schneiders (1965) proposed criteria of mental well-being as follows: (1) Mental efficiency; (2) Control and integration of motives; (3) Control of conflicts and frustrations; (4) Positive and healthy feelings and emotions; (5) Tranquility of peace of mind; (6) Healthy attitudes; (7) Healthy self concepts; (8) Adequate ego identity; (9) Adequate relation to reality. Mental well-being enhance our cognitive process, and to deal with simple as well as complex task. It also helps us in developing intrinsic motivation.

Social well-being concerned with social support and interpersonal relationship. Levitt et al., (1987) conducted a study on social support, perceived control and well-being. They find that social support was simultaneously related with health and personal control beliefs in relation to well-being. Their findings revealed that one close support figure can be sufficient to promote well-being. The high social well-being is a positive significance in coping with stresses of life, and developed high productivity to make effective community.

Hettler (1984) argued that spiritual dimension is one of the major elements of the well- being. He propounded a six dimension model of well-being. The main components of this model are intellectual, emotional, physical, social, occupational and spiritual. Myers(1992) conceptualized spiritual well-being as " a continuous search for meaning and purpose in life, appreciation for depth of life, the expanse of universe and natural forces which operate a personal belief system.''

The present investigation was carried out to study the various dimensions of well-being among the Hindu and Muslim students. Because each dimensions have its own practical as well as clinical significance for our healthy life.

## OBJECTIVE OF THE STUDY

- To determine the difference between Hindu and Muslim students on various dimensions of well-being.

## HYPOTHESIS OF THE STUDY

- Hindu and Muslim students will differ with each other on various dimensions of well-being.

### Sample of the Study

In the present research investigation sample was consisted of 96 male students (n=47 Hindu and 49 Muslim students), from different faculties of Aligarh Muslim University, Aligarh. The data was collected by multi-stage sampling technique.

### Tool Used

In psychological researches, psychological tools play very important role especially with regard to the reliability and validity of the tools. The Well-Being Scale was used for data collection. The

brief description of the scale used in the present investigation is presented in the following manner.

**Well Being Scale**

This scale was developed by Singh and Gupta (2001). This scale consisted of five sub-scale namely; physical wellbeing, mental well being, social well being, emotional well being and spiritual well being. Each sub-scale has ten items and there are 50 items in total. Scores on all the sub-scale added up to get a composite score as total well being. Minimum and maximum score can be 50 and 250 respectively. It consists of 29 positive items and 21 negative items. The test-retest reliability of the scale was 0.98 and split half reliability was found to be 0.96. Content and concurrent validity of the Well being Scale was found to be well established. Concurrent validity of the scores of well being scale was determined by comparing it with the scores of Subjective Well being Inventory Sall and Nagpal (1992).

**Procedure of Data Collection**

Good rapport was established with participants before requesting to fill up the questionnaire and then instructions were invariably explained to the participants. After that questionnaires were distributed individually. Subjects were assured of confidentiality of their responses and were requested to extend their co-operation. Finally questionnaires were collected from all the participants, scoring done and analysis was carried on.

## STATISTICAL ANALYSES AND RESULTS

**Table-1: Showing Mean SD and t-value of Hindu and Muslim Students on various dimensions of Well-Being**

| Dimensions of Well-being | Groups | N | Mean | SD | t-value (df = 94) |
|---|---|---|---|---|---|
| Physical Well-being | Hindu | 47 | 35.15 | 5.898 | 2.25* |
| | Muslim | 49 | 37.63 | 4.649 | |
| Mental Well-being | Hindu | 47 | 33.38 | 6.163 | 0.37 |
| | Muslim | 49 | 33.86 | 6.705 | |
| Social Well-being | Hindu | 47 | 33.19 | 6.540 | 2.39* |
| | Muslim | 49 | 36.27 | 6.089 | |
| Emotional Well-being | Hindu | 47 | 33.49 | 6.043 | 0.89 |
| | Muslim | 49 | 34.69 | 7.148 | |
| Spiritual Well-being | Hindu | 47 | 34.64 | 7.450 | 2.91** |
| | Muslim | 49 | 38.45 | 5.208 | |

Significant at ** 0.01, * 0.05 level.

In the present investigation the t-test has been applied to find out the significant difference between Hindu and Muslim students on various dimensions of well-being. The t- values on various dimensions of well-being such as physical, mental, social, emotional, and spiritual found to be 2.25, 0.37, 2.39, 0.89, and 2.91.The obtained t-values clearly indicate that Hindu and Muslim students are significantly differ on physical, social, and spiritual dimensions of well-being. While, there was no significant difference was found on mental and emotional dimensions of well-being between Hindu and Muslim students. So, these findings partially prove the hypothesis of the present investigation that 'Hindu and Muslim students will differ with each other on various dimensions of well-being.'

## DISCUSSION

The obtained result shows significant difference on physical, social, and spiritual dimensions of well-being among Hindu and Muslim students. The result also shows higher mean scores on each dimensions of well-being among Muslim students as compared to the Hindu students. It means that religion have a positive impact on well-being of students. Muslim students are

frequently involved in various religious activities. While at the same time Hindu students have been found rarely involved in religious activities and rituals. Therefore, the level of well-being on various dimensions in the case of Hindu students has been found on the lower side as compared to the Muslim students.

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# A Study of Mental Health Status of College Going Youths of Kashmir

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**ABSTRACT:**

This study was conducted to evaluate the mental health status among youths. Descriptive survey Method was used in this study to obtain pertinent and precise information. The hypotheses of the study were to know the relationship between mental health status and emotional stability, overall-adjustment, autonomy, self concept, security-insecurity and intelligence of youths, to find out the difference in mental health status of youth boys and girls, to find out the difference in emotional stability, overall-adjustment, autonomy, self concept, security-insecurity and intelligence. The sample of this study included 300 youths selected by stratified random sampling from the district Baramulla Kashmir. The one standardized tool was used by the investigator to evaluate the mental health status of youths in relation to their emotional stability, overall-adjustment, autonomy, self concept, security-insecurity and intelligence. In order to draw out the results the investigator used statistical techniques like t'tests, mean and standard deviation with graphical representations. The conclusions of the study are that there exists no significant difference between Mental health status and emotional stability, Mental health status and overall-adjustment, Mental health status and autonomy, Mental health status and self concept, Mental health status and security-insecurity, Mental health status and intelligence of youth boys and girls.

***Keywords:*** *Mental Health, College Going-Youths, Kashmir, self-concept, Overall-adjustment, autonomy, security-insecurity, intelligence and emotional stability.*

Mental health is not just the absence of mental illness. It is defined as a state of Well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental health is defined as the capacity to feel, think and act in ways that enhance one's ability to enjoy life and deal with challenges. Expressed differently, mental health refers to various capacities including the ability to: understand oneself and one's life; relate to other people and respond to one's environment,

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experience pleasure and enjoyment; handle stress and withstand discomfort; evaluate challenges and problems; pursue goals and interests; and explore choices and make decisions

Mental health is vital for individuals, families and communities, and is more than simply the absence of a mental disorder. Mental health is defined by the World Health Organization (WHO) as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

**DIMENSIONS OF MENTAL HEALTH:**

- INTELLIGENCE.
- OVER ALL-ADJUSTMENT.
- EMOTIONAL STABILITY.
- AUTONOMY.
- SELF CONCEPT.
- SECURITY AND INSECURITY.

**OBJECTIVES OF THE STUDY:-**

There are number of studies conducted in India and abroad on mental health status but present study focuses on the following main objectives: - The purpose of present study was to examine the dimensions of mental health status viz., emotional stability (ES), over-all adjustment (OA), autonomy (AY), security-in security (AY), self concept (SI), and intelligence (IG) in college going boys and girls of Kashmir.

**HYPOTHESIS:.**

1. There would be a significant difference between boys and girls on emotional stability dimension of mental health status.

2. There would be a significant difference between boys and girls on overall adjustment dimension of mental health status.

3. There would be a significant difference between boys and girls on autonomy dimension of mental health status

4. There would be a significant difference between boys and girls on self-concept dimension of mental health status.

5. There would be a significant difference between boys and girls on security-insecurity dimension of mental health status.

6. There would be a significant difference between boys and girls on intelligence dimension of mental health status

## METHODOLOGY:

This study includes first to select the sampling group to carry out the study. In this case, sample includes a group of youths of the age of 20-23 years. The study will then include the selection of the appropriate methods like scales to access the variables to be measured. Following the assessment of the variables, a right statistical approach is taken to authenticate the results for their significance.

**Sampling:-**The sample of the present study consisted of 300 students with equal number of boys and girls (150 boys and 150 girls) from three different colleges. The youth sample was selected from BA/B.SC I, II and III classes. All the sample units (N=300) were drawn from various colleges located in Baramulla district of Kashmir.

**Sample was collected from the following colleges of Baramulla district of Kashmir.**

**Table1**

**Showing the names of the schools**

| **Sr. No** | **Name of schools** | No. of girls | No. of boys |
|---|---|---|---|
| 1 | Govt. Degree College Baramulla | 50 | 50 |
| 2 | Govt. Degree College Sopore | 50 | 50 |
| 3 | Govt. College Pattan | 50 | 50 |

Both groups of youths (Age range 18-23) were matched in terms of their age, economic status and inhabitation.

**Tests and Materials**:

Mental Health Battery (MHB) was used in this study.

**Mental Health Battery (MHB):-**

In order to ascertain the level of mental health status among subjects, English version of Mental Health Battery developed by **Singh and Sen Gupta (1987)** was used in the present study. Mental Health Battery intends to assess the mental health status of persons in the age range of 18-23 years, as it is a battery of six (6) tests, the mental health battery consists of 130 items which are divided into six (6) parts.

**Dimension wise distribution of items for mental health battery.**

| | |
|---|---|
| Part I: Emotional Stability (ES) | 15 |
| Part II: Overall Adjustment (OA) | 40 |
| Part III: Autonomy (AY) | 15 |
| Part IV: Security Insecurity (SI) | 15 |
| Part V: Self-Concept (SC) | 15 |
| Part VI: Intelligence (IG) | 30 |
| Total | 130 |

In the battery there is no fixed time limit for first five (5) parts. However, generally in normal subject having average mental health takes about 25 minutes in giving complete answers. Part six (6) is a speed test. The total allotted time for this part is ten minutes.

1: **Analysis On the basis of Emotional Stability:** Emotional stability refers to the state of being able to have the appropriate feelings about the common experiences and being able to act in a rational manner. Emotional stability is not only one of the effective determinants of the personality patterns, but it also helps to control the growth of adolescent development. The concept of stable emotional behavior at any level is that which reflects the fruits of the normal emotional development. An individual who is able to keep his emotions stable and under control even in extreme situations, might still be emotionally stunned or be childish in his behavior sometimes. Therefore emotional stability is considered as one of the important aspect of human life. People must be able to control their emotions adequately and also express them appropriately. Below given table indicates that there does not exist any significant difference between the two groups on emotional stability.

***Table.1 Comparison of two groups on Emotional Stability***

| Variable | Group | N | **Mean** | **SD** | **t** | **P** |
|---|---|---|---|---|---|---|
| Emotional Stability | Boys | **150** | 8.32 | 1.926 | .274 | **NS** |
| | **Girls** | **150** | 8.26 | 1.862 | | |

A perusal of table 1 reveals that mean emotional stability scores of youth boys and girls were 8.32 and 8.26, with SD 1.926 and 1.862 respectively. The t-ratio between the means of the two groups was found to be .274 which was not significant at 0.01 level of significance.

**Ciarrochi *et al***. suggested that emotional indicators and stressor factors impacted on socio-psychological health status. **Salovey,** that EI was associated with mental health, and individuals with higher EI were able to deal better with stress and were less vulnerable in stress.

**2. Analysis On the basis of Overall adjustment:** Adjustment is a built – in mechanism for coping with the problematic or other realities of life. Adjustment has been considered as an index to integration; a harmonious behavior of the individual by which other individual of society recognize person is well adjusted. (**Pathak, 1990). Below drawn table shows that on overall adjustment there does not exist any significant difference between two groups.**

***Table.2 Comparison of two groups on Overall adjustment***

| Variable | **Group** | **N** | **Mean** | **SD** | **t** | **P** |
|---|---|---|---|---|---|---|
| ***Overall adjustment*** | **Boys** | **150** | 25.33 | 4.261 | .246 | **NS** |
| | **Girls** | **150** | 25.21 | 4.186 | | |

A look at table 2 reveals that mean overall adjustment scores of youth boys and girls were 25.33 and 25.21, with SD 4.261 and 4.186 respectively. The t-value between the means of the two groups was found to be .246 which was not significant at .01 level of significance.

**Menninger (1945)** defined mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness.
**Anand (1999)** conducted a study on mental health of 370 students of IX, X, XI and XII grades. He reported no significant impact of gender and class on the mental health.

**3. Analysis On the basis of Autonomy;** Autonomy is an individual's capacity for self-determination or governance. Autonomy is generally held in high esteem. It serves as one of the central concepts in many philosophical debates, e.g. on understanding ourselves as persons, on how to conceptualize morality, on the legitimization of political norms and practices as well as on questions in bio-medical ethics. The table does not show any significant difference between two groups on Autonomy.

***Table: 3 Comparison of two groups on Autonomy***

| Variable | **Group** | **N** | **Mean** | **SD** | **t** | **P** |
|---|---|---|---|---|---|---|
| ***Autonomy*** | **Boys** | 150 | 7.59 | 1.589 | .432 | **NS** |
| | **Girls** | 150 | 7.51 | 1.617 | | |

Table 3 depicts that the mean Autonomy scores of youth boys and girls were 7.59 and 7.51, with SD 1.589 and 1.617 respectively. The t-value between the means of the two groups was found to be .432 which was not significant at .01 level of significance.

Autonomy has been identified as an intrinsic psychological need that, when realized, promotes mental health and well-being. The failure to develop autonomy, it has been hypothesized, may lead to decreased motivation and lowered self-esteem **(Ryan & Deci, 2000).**
Autonomy represents a cornerstone of psychological theories of personality development **(Mahler, Pine, & Bergman, 1975)** maintained that the development of an autonomous and psychological healthy person resulted from the process of separation and individuation.

**4 Analysis on the basis of Self-Concept;** Self-concept is the way people think about themselves. It is unique, dynamic, and always evolving. This mental image of oneself influences a person's identity, self-esteem, body image, and role in society. As a global understanding of one's self, self-concept shapes and defines who we are, the decisions we make, and the relationships. Self- concept is perhaps the basis for all motivated behavior. Table is the indicator that there is no significant difference on self-concept between the two groups.

***Table: 4 Comparison of two groups on Self-Concept***

| Variable | **Group** | **N** | **Mean** | **SD** | **t** | **P** |
|---|---|---|---|---|---|---|
| *Self-Concept* | Boys | **150** | 7.71 | 1.256 | .369 | NS |
| | Girls | **150** | **7.65** | 1.248 | | |

A perusal of table 4 reveals that mean self-concept scores of youth boys and girls were 7.71and 7.65, with SD 1.256 and 1.248 respectively. The t-ratio between the means of the two groups was found to be .369 which was not significant at 0.01 level of confidence. Self-concept is the sum of an individual's beliefs and knowledge about his personal attributes and qualities, it is a cognitive schema that organizes abstract and concrete views about the self, and controls the processing of self-relevant information **Markus, 1977; Kihlstrom and Cantor, 1993** Self-concept is considered as equivalent to self-regard, self-estimation and self-worth **(Harter, 1999)**. Sartorius **(Sartorius, 1998)**, the former WHO Director of Mental Health, preferred to define it as a means by which individuals, groups or large populations can enhance their competence, self-concept and sense of well-being.

According to Tudor **(Tudor, 1996)**, self-concept, identity and self-esteem are among the key elements of mental health. Again **(1996)** in his monograph on mental health promotion, where he presents self-concept and self-esteem as two of the core elements of mental health, and therefore as an important focus of mental health promotion.

**5 Analysis on the basis of Security-Insecurity**

**Security:**

In contexts of poor security, public health interventions and the delivery of health care to the individual are more difficult to perform and less likely to succeed than in contexts of security. Violence — including the threat of violence — in such contexts results in injury, death, psychological harm, impaired development or deprivation.

**Insecurity:**

Insecurity, therefore, potentially has a double impact on people's lives and well-being; this is the reality of everyday life for many millions of people. The nexus of security, insecurity and health is as complex as it is important. In a given context, responsibility for what happens at this nexus falls to multiple actors, including ministries responsible for health, defense and internal affairs; the overriding influence, especially on security, may even be the foreign policy of other countries. On security-insecurity table does not indicate any significant difference between the two groups.

***Table: 5 Comparison of two groups on Security-Insecurity***

| ***Variable*** | ***Group*** | ***N*** | ***Mean*** | ***SD*** | ***t*** | ***P*** |
|---|---|---|---|---|---|---|
| ***Security-Insecurity*** | ***Boys*** | ***150*** | 7.63 | 1.662 | .471 | ***NS*** |
| | ***Girls*** | ***150*** | 7.54 | 1.536 | | |

Table 5 depicts that the mean security-Insecurity scores of youth boys and girls were 7.63 and 7.54, with SD 1.662 and 1.536 respectively. The t-value between the means of the two groups was found to be .471 which was not significant at .01 level of significance. Young people development is due to love and affection and sense of security which is further dependent on the attitude of parents towards their children **(Bossard & Boll, 1954)**. The insecurity state of a person is an emotional problem, a state of being in disturbance due to the feeling of tension, strain and conflict together with other consequences of tension.

According to **Shankar, (1958)** emotional security prepares the ground for mental health and creative activities of the individuals by which they make adjustments to their environment.

## 6 Analysis on the basis of Intelligence

A very general mental capability that, among other things, involves the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas, learn quickly and learn from experience. It is not merely book learning, a narrow academic skill, or test-taking smarts. Rather, it reflects a broader and deeper capability for comprehending our surroundings-"catching on," "making sense" of things, or "figuring out" what to do. Intelligence has been defined in many different ways such as in terms of one's capacity for logic, abstract thought, understanding, self-awareness, communication, learning, emotional knowledge, Memory, planning, and problem solving. Below given table proves that there is no significant difference between two groups on intelligence.

***Table: 6 Comparison of two groups on Intelligence***

| ***Variable*** | ***Group*** | ***N*** | ***Mean*** | ***SD*** | ***t*** | ***P*** |
|---|---|---|---|---|---|---|
| ***Intelligence*** | ***Boys*** | ***150*** | 17.85 | 3.772 | .595 | NS |
| | ***Girls*** | ***150*** | 17.59 | 3.630 | | |

A look at table.6 reveals that mean Intelligence scores of youth boys and girls were 17.85 and 17.59, with SD 3.772 and 3.630 respectively. The t-value between the means of the two groups was found to be .595 which was not significant at .01 level of significance.**Goleman (1995)** suggested the need to bring intelligence to emotions. Goleman tells us that we really have two different ways of understanding, intellectually and emotionally and our mental life results from the interaction of both functions. It means mental health directly depends on head and heart because intellectual development depends on head (brain) and emotional development depends on heart.

## CONCLUSIONS

Results of the study show the acceptance or rejection of the hypotheses. Conclusions of study are:

1. There exists no significant difference between boys and girls on emotional stability dimension of mental health.
2. There exists no significant difference between boys and girls on overall adjustment dimension of mental health.
3. There exists no significant difference between boys and girls on autonomy dimension of mental health.
4. There exists no significant difference between boys and girls on self-concept dimension of mental health.
5. There exists no significant difference between boys and girls on security-insecurity dimension of mental health.
6. There exists no significant difference between boys and girls on intelligence dimension of mental health.

**SUGGESTIONS:**

1. The Study can be conducted on college going and university level students.
2. The study can be conducted by considering the High and Low mental health.
3. The Mental health of teachers can be evaluated too.
4. Other variables like Anxiety, self- efficacy, emotional intelligence, academic motivation and other constructs can also be included for further research.

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# Strategies to effectively control Aggression: A case study

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**ABSTRACT:**

Individuals who are socially connected are happier and healthier than their more isolated counterparts. Over the past few decades, researchers have established that both the quantity and quality of our social relationships are unequivocally important when it comes to our physical and mental health, and our risk of mortality. Although the link between social relationships and mental health is well established in a couple, we have only just begun to identify explanations for this link. Recently, social scientists have discovered that the link between social relationships and health is explained by our behaviours (e.g., smoking, exercise, diet), various psychosocial factors (e.g., social support, mental health, cultural norms), and physiological processes. Aggression in marital relationship is defined as a manipulative, physical or non-physical form of aggression meant to negatively impact the development of relationship by social exclusion or harming the social status of a victim by spreading or behaving negatively. Research findings suggest that even infrequent experiences with relational aggression victimization are associated with lower subjective well-being such as depression, loneliness, and positive affect. This case study investigates the existence of relational aggression in a couple and the relationship between relational aggression and own subjective well-being. The participant in the study is married and from nuclear family. The study tries to investigate aggression level through the case study method and relaxation, yoga, meditation techniques used which was used to resolve the aggression and helps to achieve well being.

***Keywords:*** *Aggression, Relaxation, yoga, meditation.*

Aggression is a kind of harmful social interaction with the intension of inflicting damage or destruction upon another individual. It may occur without provocation or may be frustration due to blocked goals can cause aggression. Being aggressive is not at all good as it takes away the communication between our minds our body. Aggression is that feeling of mind in which we get tensed and angry over wanted or unwanted reasons. Any person who gets angry over silly reasons is considered to be a troublemaker even though he may actually be a good person. Aggression simply gives a sudden satisfaction of mind while we are in a raised situation but the after effects which it brings to us are not easy to be handled.

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You might get aggressive for a reason which we think is right, but for the other person or group of people who listens to you might not feel great about it. Being aggressive can usually destroy the depth of relation between two people, even without the knowledge of the one who is being aggressive. Aggression as a behavioural phenomenon indicates that Aggression Behaviour may stem from learned habits of responding as well as from excessive (Bandura 1965). It may be expressed in terms of irritation; quarrelling and fighting disrespect to elder's negative reaction to traditional and believes etc. Mc Clelland and Apicella (1945) have also done significant works, in the context of Frustration-aggression hypothesis, by creating frustration in the laboratory. Aggression at work is usually defined as any form of aggressive behaviour with the intention to harm the victim and the behaviour used may be both physical and psychological in nature (Baron & Neuman, 1998; Baron & Richardson, 1994; Geen, 1990). The society simply puts aside those people who gets angry over small reasons, and never cares about what that person says even in a complicated problem over which he might have a large number of ideas or suggestion. Being aggressive also puts us into a tedious approach to the on goings after the angry situation as we keep on thinking about the problem again and again. Too much of unwanted thoughts also have bad effects on our mental stability and physical capabilities. Verbal and psychological aggression seems to be more prevalent than physical aggression and violence (Baron & Neuman,1996; Bulatao & VandenBos, 1998; Di Martino, Hoel, & Cooper, 2003). Physical-verbal aggression is defined according to whether the aggression is expressed through physical acts like hitting or verbal acts such as threats. Once we are angry, we cannot focus on what is happening around us but just on how we can make the other fellow understand what our mindset is or what kind of a suggestion we would like to present. The feeling which usually gets people to be aggressive is that when they think of themselves as they cannot handle the situations in their life. But once a person gains confidence over his own abilities, any consequences in life can be handled within no sweat. And also, the people who cares for the happiness of other people rather than their own, usually has a clear perspective of what to do and does not indulge in unwanted problems .We might be thinking to limit ourselves, but our body simply works on its own. The situation will be turn into mess.

## AGGRESSION AND RELATIONSHIP

Aggressiveness is a mode of communication and behaviour where one partner expresses their feelings, needs and rights without regard or respect for the needs, rights and feeling of others. However, considering both partners' aggression allows for a more complete understanding of dysfunction in the relationship system, especially because aggression may be an interactive and synergistic phenomenon for some couples (Vivian & Langhinrichsen-Rohling, 1994). Emotion or physical forces are often used and person feel victimised and their relationships suffer. .Furthermore, similar to physical aggression, emotional aggression is often bidirectional (Hines & Saudino, 2003; Swan & Snow, 2002). Although the perpetration of emotional and physical aggression is highly correlated (Hamby & Sugarman, 1999; Hines & Saudino, 2003; Murphy & O'Leary, 1989), little is known about the trajectory of emotional aggression over time, and whether it follows a similar pattern as physical aggression In relationship aggression is not good

for the aggressor and as well as the partner facing aggression. The relationship conflict leads to stress and it affects both the partner in many ways. It can impact on their relationship and stress level and it can also affect on their health and happiness. Now a day's different strategies were used to control aggression like yoga, meditation, relaxation etc are being introduced to minimise the stress level and aggression among the individual .The yoga plays an important role in keeping the stress level and aggression down and also helps to improve the concentration power and to keep them calm and relax and more focused towards their goals . Moreover, importance should be given to the above mentioned strategies more and more over stress level and aggression will automatically become low when individual are healthy. So, such steps should be taken by every individual to improve themselves and to live a happy and peaceful life and help us to reach their desired goals. Temple, Weston, & Marshall (2005), for found that aggression is more severe and frequent in relationships where both partners are aggressive.

## OBJECTIVE OF THE STUDY

The main objective of the study is to see the impact of relaxation, yoga and meditation to control aggression which leads to a happy and healthy life.

## CASE STUDY

In the present research case study method is used. In the present case study, a couple who were happily living but after many years spending together but now they are facing aggression and disturbed family environment. Interview was done to select the participant. The Participant of the present study Raghav Arora (name changed) aged 25, who was married from last 2years and according to him he was very happily living with his partner but in the past due to blocking of goals and facing lot of failures leads to anger, hatred, de-motivation and aggression. It was also put impact on his married life, regular fight were common in their life, love decreases and fights increases.

After the interview with the participant, his wife and other family members it was concluded that due to his aggression the whole family is being victim of it and all are suffering for the same. It was a deep study to understand how aggression is affecting his life. In the present study confidentially was maintained so he could open up without any hesitation.

Earlier he was working in Private sector but now he is not working. He is preparing himself for government job .He is eldest in his family, he has younger sister. He had lost his father when he was in 10th standard and his mother is house wife. He is very close to his mother and very friendly in nature. He feels comfortable and happy with those whom he is close too . He was in relationship from last 5 years and now he got married. Raghav is close to two of his childhood friends and his wife who was earlier his girl friend. He has done engineering and 2years he

worked in private sector and according to him in private sector he has to give lot of input but output is low being eldest in the family he has responsibility of everyone in his family like mother, sister, wife. He decided to give up private job and start preparing for government job exams. This was very big decision for him and for his family as there was no one earning in the family. When he was in 10th class his father passed away, at that time he has faced mental pressure to stand himself and to support his family to secure their future and to fulfil their basic necessity. From class 10th till engineering he was under pressure and he got continuous support from his other family members and motivated him to study. After the completion that he got job and got engaged with his girl friend, both the families were very happy. In his job his income was nominal and he was facing difficulty to fulfil the demands of everyone. From that time he had started facing a lot of mood swings, stress and anger because of lot of work pressure and family pressure. There was continuous support from his Fiancé they both partner had a very good understanding level and very high compatibility. She understands him at every point and motivated him to work. She was the one who helps him to balance his emotions, feelings etc. When Raghav sees a competition level is too high and his friends were earning was much better than him makes him more anxious and worried because he has lot of responsibility and then he decided to give up private job and to prepare for government job exams. During this time his stress and aggression level increased a lot he started showing mood swings, irritation, frustration, he wants to live alone all the time. Negative thoughts were increased and feels highly de-motivate. He doesn't want to spend time with his childhood friends and his Fiancé with whom he feels more relaxed and comfortable. He started ignoring them. He was socially isolated. There was lot of disturbance in sleeping patterns. He feels lethargic. He feels anxious and not able to concentrate on his studies. There were lots of thoughts popping in his mind related to his future which was making him more and more anxious. His relationship started destroying with his mother, sister and Fiancé. His fights increased with them. They give him some suggestion but he takes everything negatively. He become short tempered and shouts on everyone. He tries to be commanding and dominating .he started avoiding his Fiancé, he doesn't want to spend time with her. Their relationship started ruining .Both the partner faced lot of difficulty to understand each other in that difficult situation but Raghav attitude was very negative and aggressive which is very problematic for both of them. There were many times in his life he was considered too aggressive to be talked with. His family member stopped commanding him as they felt that it would not give them positive reply and instead just tear through them. When people accuse him of mistake which he did not commit, he used to get as angry over the matter as the only thing he feel like is to prove his innocence, But unknowingly, by being aggressive, he was a stubborn and spoilt person .His aggressiveness has affected his life in a relatively bad manner. He literally went away from his house, shouted at his family member and fiancé, insulted anyone who confronted him with advice and threw away those sympathetic people who regretted for his situation .His fiancé whom he used to be very close with, started telling him that she is worried about his sudden reactions and bad approach to several problems in his life. Showing sympathy was something she always did. Hence he threw her out of his life and wants to be separate from her and feels that she is not close to him anymore.

After taking the interview from his family and Fiancé and regular interaction with Raghav found lot of issue in his behaviour. To keep his mind and body calm and balanced form we have done 12-15 sessions, one hour each with him. The main intension of this intervention was to focus on his positive behaviour, work on his hobbies and interest. Relaxation techniques was used to control his aggression to keep his mind and body calm , avoid negative thoughts .with relaxation techniques we have also asked him to add other effective strategies like yoga , meditation in his daily routine which will help him to control aggression. In the starting he doesn't pay attention but gradually he started showing interest and started cooperating with us .After the intervention there was changes in his behaviour he was quite calm and relax he started understanding the things in a right way. less anxious and worried. Reduce in mood swings. He feels positive and energetic to do his work .motivational level increased .Don't shout and fight with his family member and fiancé. He started realising fiancée importance in his life. He wants her back in his life. He feels incomplete without her. He started balancing his emotions feelings etc feels sorry for his behaviour, and got married.

## DISCUSSION AND CONCLUSION

It is generally found that aggression and stress level have been found more in boys than girl as shown in the study. Boy have more aggression due to the fact that parents have a feeling that boys are more capable of handling their property and business including other household and social responsibility, family has higher expectation from the males to excel in life. Due to this fact parents expect more from boys. This is a major cause of increasing aggression level in the participant. Some individual are not capable of handling so much aggression and stress and they find it easier to escape from the situation rather than living a life full of aggression and stress. As a result divorced rate or separation among couples is increasing at a fast rate. Moreover Family and wife expectation on their husband or son is increasing day by day which is another cause of increasing aggression level among individual. In today's time High completion level and nominal income creates lot of pressure to fulfil demands and responsibility of his family. Sometime the individual are influenced by the society in which they are living and trying to fulfil their demand and responsibility and to maintain there status. All these factors affect the couple relationship their emotions, understanding and feelings. It was believed that they should understand each other and balance themselves to settle or manage their relationship and family.

Keeping our mind and body calm is one of the best ways to control aggressiveness. Although female victims are often the focus of intimate violence research, the considerable rates of aggression towards men (e.g. Archer, 2000) suggest the need to evaluate both male and female aggression. Clearly women suffer more severe consequences due to partner aggression (Archer, 2000; Holtzworth-Munroe, Smutzler, & Bates, 1997) and the context of and motivations for female perpetrated aggression may be different (Swan & Snow, 2006); however Relationship is destroyed because of aggression that one of the partner is more aggressive and commanding which cause difference in their relationship.Controlling our anger is not easy but there are many ways to control it if we have the confidence. There are effective strategies which provide help to those people who cannot keep control over their state of mind in certain situations. Meditating in

the morning at a calm and lonely place which keeps our mind fresh, keeping ourselves engaged in good company etc. Daily start walking and doing relaxation techniques .Start knowing your positive aspect of your life. Usually aggressiveness cannot be controlled at the moment unless we have a calm and peaceful mind or else we should be practised to keep ourselves in control. These techniques can be used with wider range to maintain wellbeing of married couples.

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# A study of resilience and social problem solving in urban Indian adolescents

Bhawna Sharma[1]

**ABSTRACT:**

This paper investigates the relation between resilience and social problem solving among Indian adolescent boys and girls from a north Indian urban area. With the advent of information technology tools, multinational brands and privatisation of higher education in India, there has been a surge in the ambitions of the millennial Indian youth. This has also resulted in extreme competition, failure and non resilient outcomes for many. This study was conducted to find the level of correlation between resilience and social problem solving skills. The study revealed that adolescents high on resilience were significantly better on social problem solving skills, superior positive orientation towards problems in general and a rational approach towards solving them as well. Since resilience is a dynamic construct, problem solving training can be used to enhance resilience in adolescents facing mental health issues arising out of the typical urban Indian milieu.

***Keywords:*** *adolescence, urban, resilience, social problem solving*

Adolescence has been referred to as a turbulent transition both for the young and their caregivers throughout generations and across the world. Yet, development of individuals is contextual to culture, demography and ecology of that place. The desires and values of the millennium Indian adolescent present a paradox for caregivers, educators and mental health professionals. These teens are a highly opinionated, liberated and motivated lot but their soaring ambitions are juxtaposed against the harsh realities of rigid cultural boundaries, scarce resources and at times stifling competition for college seats, jobs and even for acceptance by peers. Although the adolescent mental health status is an issue for the whole of Indian society; there is a definite psychosocial segregation between the rural and urban youth.

There is considerable difference between the upbringing, experiences, emotional competencies, and the psychological developmental trajectories of rural and urban Indian adolescents. According to UNICEF statistics of 2012, 20% of the Indian population lies in the age group of 10-19 years and almost half of it resides in the urban areas.

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The adversities faced, challenges undertaken and conflicts experienced are different for the rural and urban adolescent. It's not the earthquakes, tsunamis, droughts or floods that are the risk factors for the average Indian urban adolescent. Rather, disruptive family environment, extreme academic competitiveness, poor support systems, unrealistic expectations from romantic associations and excruciating levels of peer pressure are the daily hassles that erode the mental health of the urban Indian teenager. Though the outcomes are not all that grim for the majority of the youngsters, it is imprudent to disregard the increasing trends of teenage depression and suicides among Indian youth.

A significant chunk of Indian youth is contributing tremendously to the global pool of education, business and information technology. At the same time they have counterparts who cannot deal with competitiveness and the stress to perform. So what is it about some individuals which allows them to bounce back after setbacks and the absence of which results in negative outcomes for many? It's a cluster of individual and environmental factors called *Resilience.*

Resilience, the ability to bounce back after any failure, loss or trauma is one of the most important life skills that an individual needs to protect, sustain, and enrich ones existence in the world today. The term *resilience* has often been used to describe a stable personality trait or ability that protects individuals from the negative effects of risk and adversity (Hollister-Wagner, Foshee, & Jackson, 2001; Howard & Johnson, 2000; Walsh, 2002).

According to Smith & Carlson (1997), the adolescent population may be especially susceptible to stressful events, and perceive some events as more stressful than an adult might. Adolescents differ from adults in the way they behave, solve problems, and make decisions. There is a biological explanation for this difference. Scientists have identified a specific region of the brain called the *amygdala* which is responsible for instinctual reactions including fear and aggressive behavior. This region develops early. However, *the frontal cortex*, the area of the brain that controls reasoning and helps us think before we act, develops later. This part of the brain is still changing and maturing well into adulthood. Pictures of the brain in action show that adolescents' brains function differently than adults when decision-making and problem solving. Their actions are guided more by the amygdala and less by the frontal cortex. Based on the stage of their brain development, adolescents are more likely to: • act on impulse • misread or misinterpret social cues and emotions • get into accidents of all kinds • get involved in fights • engage in dangerous or risky behavior *(*American Academy of Child and Adolescent Psychiatry, 2012*).* Those who are less resilient may turn to unhealthy actions or negative beliefs about themselves to cope with the difficulties encountered in their lives (Smokowski, 1999).Vulnerable youth are at greater risk for failing out of school, choosing harmful associates, experiencing desolation and homelessness, experimenting with substance use, and unsafe sexual encounters. Not having adequate individual or environmental compensatory factors during such times leads such youth into hopelessness and suicidal or homicidal tendencies. On consequent analysis of most of the suicide and homicide cases involving young lives; it has been found that lack of emotional

regulation and social problem solving skills led to the plunge into the nadir of depression for these adolescents. Not having a sense of control over one's life and not knowing how to deal intelligently with people and systems is often the cause of low self esteem and poor confidence levels in adolescents. The deficits of this age need the aid of good social problem skills and dependable support system for transforming into unsullied, creative, bouncy harbingers of change.

One of the key abilities associated with resilience is problem solving. Learning problem-solving skills is a significant contributor to an individuals' socio-emotional wellbeing. (Pearson & Hall, 2006). The term social problem solving refers to problem solving as it occurs in the natural environment or real world. It is defined as the self- directed cognitive –behavioural process by which a person attempts to identify or discover effective or adaptive solutions for specific problematic situations encountered in the course of everyday living. (D'Zurilla & Maydeu – Olivares, 1995; D'Zurilla & Nezu, 1982, 1999). The most widely used approach by D'Zurilla & Nezu describes problem solving in terms of two main ingredients. Firstly, 'Problem orientation' i.e. , whether you have a 'positive' or 'negative' attitude towards life's problems in general. (Robertson D.J, 2012). *Positive Problem* Orientation (PPO) is described as a constructive problem solving cognitive set that involves the general disposition to appraise a problem as a challenge for benefit rather than a threat, believe that problems are solvable, believe in ones' personal ability to solve problems successfully, to believe that successful problem solving takes time, effort, and persistence, and committing oneself to solving problems with dispatch rather than avoidance.

*Negative Problem Orientation* (NPO) is the dysfunctional or inhibitive cognitive emotional set that involves the general tendency to view a problem as a significant threat to well being, doubt one's personal ability to solve problems successfully and become frustrated and upset when confronted with problems in living.(D'Zurilla & Maydeu –Olivares, 1995; D'Zurilla & Nezu, 1982, 1999).

The second ingredient of social problem solving is the 'Problem-solving style', which can be classed as either unhelpful (termed 'impulsive/careless' or 'avoidant') or helpful (termed 'rational') (Robertson D.J, 2012). *Impulsivity Style* – (IS) is a dysfunctional problem solving pattern characterised by active attempts to apply problem solving strategies and techniques. However, these attempts are narrow, impulsive, careless, hurried, and incomplete. *Avoidance Style* (AS) is another dysfunctional problem solving dimension characterised by procrastination, passivity or inaction, and dependency. *Rational Problem Solving* (RPS) is a constructive problem- solving style that is defined as a rational, deliberate, systematic, and skilful application of effective or adaptive problem- solving principles and techniques. (D'Zurilla & Maydeu – Olivares, 1995; D'Zurilla & Nezu, 1982, 1999).

Resilient youth tend to have strong social skills and a facility with interpersonal communication (Hollister-Wagner et al., 2001; Howard & Johnson, 2000; Luthar, 1991; Smith & Carlson, 1997; Werner, 1995). Also evident are humour, empathy, flexibility, and an easygoing temperament,

all of which are likely to enhance sociability (Bernard, 1993; Fraser & Richman, 1999; Levine, 2002; Richardson et al., 1990; Rutter, 1987).

Challenges and adversities are a part of normal life and in fact looking at life through rose tinted glasses is a mistake that today's youth cannot afford to make. Lower social and emotional competencies have impacted on the present generation with an increase in illicit drug and alcohol abuse, road rage, intentional delinquent behaviour (that is often repeated), mental illness, eating disorders, obesity, homelessness and premature deaths as a result of poor decision making.( Dent M., 2008).Suicide, homicides and depression statistics of Indian youth are clearly indicative of the hopelessness, poor social support and lack of adequate problem solving skills.

The development of core social skills is an important protective factor for good mental health in later life (Werner, 1989). But perhaps with both parents working, nuclear family systems, more time spent with gadgets and in the virtual world, there isn't much of real world problem solving being learnt. And as is the case with all the other skills, if social problem solving is not learnt and practised as a life skill it will not be ameliorative. As protective and risk factors for resilience are mostly culture specific, we need to ascertain the determinants of a resilient outcome for Indian adolescents as well. Studying the relationship between resilience and social problem solving among Indian adolescents is an endeavour in this direction.

Based on the review of literature, the key hypotheses are as follows:

1. Adolescents would have significant relationship between resilience and social problem solving.
2. Adolescents would have significant relationship between resilience and all the dimensions of Social problem solving.
3. Adolescents exhibiting different levels of resilience would also differ on social problem solving skills.
4. Adolescents differing on their levels of resilience would also differ on all the dimensions of social problem solving skills.

## METHOD

### *Participants*

The study was conducted on 211 adolescent boys and girls aged 13 – 16 yrs studying in two English medium schools of an urban city of north India. Systematic sampling was undertaken for the above.

### *Measures*

*Resilience*

Resilience was measured using the Resilience Scale (RS) (Wagnild & Young, 1993). This 25-item inventory provides a total resilience score ranging from 25-175.It describes a psychological ability that allows a person to cope effectively with life stresses. Items are scored on a seven-point scale ranging from 1 (strongly disagree) to 7 (strongly agree).This scale has two major

factors, viz., acceptance of self and life, and individual competence (Wagnild & Young, 1993). This scale is appropriate for younger individuals as well as middle-aged and older adults. Cronbach's alpha coefficients have been found to range from 0.72 to 0.94 (Neill & Dias, 2001). Test-retest reliability has been reported to range between 0.67 to 0.84 by Killien and Jarretiss (1993). This scale has shown considerable construct validity with constructs such as morale and life satisfaction (positively related), and depression and perceived stress (negatively related).

### *Social problem solving skill*

The social problem solving skill was assessed using the Social Problem Solving Inventory – Revised: Short Form-SPSI-R: S ( D'Zurilla, Nezu & Olivares, 2002). This 25-item inventory is a useful measure of better understanding how an individual typically resolves stressful problems and makes effective decisions. It assesses two constructive or adaptive problem- solving dimensions (positive problem orientation and rational problem solving) and three dysfunctional dimensions (negative problem orientation, impulsivity/ carelessness style, and avoidance style). The internal consistency alpha coefficient is .89 for the normative sample of young adults and the test-retest reliability is .84 for the above. Predictive validity of SPSI-R: S on correlation with several measures of psychological distress and well being are significant indicating that SPSI-R: S is a valid and stable measure of social problem solving abilities.

### *Procedure*

The scales were administered to the participants in groups in the regular classroom situation. Both the scales were administered on separate days with a gap of 7 school days in between. Although the instructions provided on the scale booklets were self explanatory, the researcher explained the purpose of the study and instructions to the pupils in class.It took 30- 40 minutes to administer each measure. The answers of the subjects were recorded on the scale protocol. Scoring was done according to the instructions given in the manuals. After the scores were obtained, interested participants were explained the interpretations of their scores on the two measures.

### *Statistical analysis*

In order to analyse the data, the sample was classified into two groups based on the median score of the sample on the Resilience Scale. As the median score was 123, two groups were formed. The Low resilience group with scores < 123 had 108 pupils. The high resilience group with scores >123 had 103 participants. All the statistical analysis was done with the statistical software SPSS.

Pearson product moment correlation was calculated between the Resilience scores and Social Problem Solving scores of the whole sample. Also, correlation was calculated between Resilience scores and scores on the five dimensions of Social Problem Solving – Positive Problem Orientation, Negative Problem Orientation, Rational Problem Solving, Impulsivity style and Avoidance style.

Independent samples t-test was undertaken to study the difference in means of Social Problem Solving scores between the low resilience and high resilience groups. Also, Independent samples t-test was applied to study the difference in means of Positive Problem Orientation,

Negative Problem Orientation, Rational Problem Solving style, Impulsivity style and Avoidance style dimensions scores of the low resilience and high resilience groups.

## RESULTS

### *Resilience and Social problem solving correlations*

The constructs of resilience and social problem solving are significantly related in this sample of urban adolescents in India. These results validate the first hypothesis of this study. Table 1 shows the value of Pearson correlation coefficient between the total score on social problem solving and resilience as significant at the 0.01 level.

It is a positive correlation indicating that the presence of one variable might facilitate the presence of the other in an individual. (**Table 1)**

**Table 1**

Pearson Correlation coefficient 'r' between Resilience, Social problem solving and dimensions of social problem solving.

| | | RESILIENCE | SPS-TOTAL |
|---|---|---|---|
| Pearson Correlation | RESILIENCE | 1.000 | .322** |
| | SPS-TOTAL | .322** | 1.000 |
| Sig. (2-tailed) | RESILIENCE | | .000 |
| | SPS-TOTAL | .000 | |
| N | RESILIENCE | 211 | 211 |
| | SPS-TOTAL | 211 | 211 |

** Correlation is significant at the 0.01 level (2-tailed).

### *Resilience and dimensions of Social Problem solving*

The correlation between the positive problem orientation-PPO dimension of social problem solving and resilience is positive and significant in this sample. Table 2 depicts the Pearson product moment correlation between the two. Since, it is a positive correlation the presence of traits like optimism, self-efficacy and engagement in problems rather than avoidance, may be a part of a resilient personality.

**Table 2**

Pearson product moment correlation coefficient 'r' between Resilience and Positive problem orientation.

| | | RESILIENCE | PPO |
|---|---|---|---|
| Pearson correlation | RESILIENCE | 1.000 | .496** |
| | PPO | .496** | 1.000 |
| Sig. ( 2-tailed) | RESILIENCE | | .000 |
| | PPO | .000 | |
| N | RESILIENCE | 211 | 211 |
| | PPO | 211 | 211 |

** Correlation is significant at the 0.01 level (2-tailed).

Table 3 illustrates the correlation coefficient between resilience and negative problem orientation. The Pearson product moment correlation between the Resilience scores and the Negative problem orientation NPO dimension of social problem solving is not significant at any level indicating no correlation between the two variables at least in this sample.

**Table 3**

Pearson product moment correlation coefficient 'r' between Resilience and Negative problem orientation

| | | RESILIENCE | NPO |
|---|---|---|---|
| Pearson Correlation | RESILIENCE | 1.000 | .101 |
| | NPO | .101 | 1.000 |
| Sig. ( 2-tailed) | RESILIENCE | | .144 |
| | NPO | .144 | |
| N | RESILIENCE | 211 | 211 |
| | NPO | 211 | 211 |

The Pearson product moment correlation between the construct of Resilience and the Rational problem solving style ( RS ) dimension of Social problem solving is significant at the 0.01 level (Table 4). It is a positive correlation indicating that the there is probability of a rational person being more resilient at least in this sample.

**Table 4**

Pearson product moment correlation coefficient 'r' between Resilience and Rational problem solving style.

| | | RESILIENCE | RS |
|---|---|---|---|
| Pearson Correlation | RESILIENCE | 1.000 | .392** |
| | RS | .392** | 1.000 |
| Sig. ( 2-tailed) | RESILIENCE | | .000 |
| | RS | .000 | |
| N | RESILIENCE | 211 | 211 |
| | RS | 211 | 211 |

** Correlation is significant at the 0.01 level (2-tailed).

The Pearson product moment correlation between Resilience and the Impulsivity style dimension of the Social problem solving is not significant at any level (Table 5) indicating no correlation between the two variables at least in this sample.

**Table 5**

Pearson product moment correlation coefficient 'r' between Resilience and Impulsivity style.

| | | RESILIENCE | I S |
|---|---|---|---|
| Pearson Correlation | RESILIENCE | 1.000 | -.042 |
| | IS | -.042 | 1.000 |
| Sig. ( 2-tailed) | RESILIENCE | | .548 |
| | IS | .548 | |
| N | RESILIENCE | 211 | 211 |
| | IS | 211 | 211 |

The Pearson product moment correlation between the Resilience scores and the Avoidance style dimension of Social problem solving is not significant at any level (Table 6), indicating no correlation between the two variables at least in this sample.

**Table 6**

Pearson product moment correlation coefficient 'r' between Resilience and Avoidance style

| | | RESILIENCE | AS |
|---|---|---|---|
| Pearson Correlation | RESILIENCE | 1.000 | -.055 |
| | AS | -.055 | 1.000 |
| Sig. ( 2-tailed) | RESILIENCE | | .425 |
| | AS | .425 | |
| N | RESILIENCE | 211 | 211 |
| | AS | 211 | 211 |

*The Independent- samples t-test results for Social Problem Solving*

There is significant difference in the mean scores of the low resilience and high resilience groups on social problem solving as depicted in Table 7.

**Table 7**

Comparison of means on social problem solving

| Sr. No. | Variable | Group | Mean | SD | df | t-value |
|---|---|---|---|---|---|---|
| 1 | Social Problem Solving | Low resilience. ( N = 108) | 10.78 | 1.85 | 209 | - 4.324* |
| | | High resilience. (N = 103) | 12.00 | 2.23 | | |

***** Significant at 0.01 level.

The mean scores of the Positive Problem Orientation dimension and the Rational Problem Solving dimension differ significantly across the low and high resilience groups. The t- values are significant at the 0.01 level. The mean scores of the Negative Problem Orientation, Impulsivity and Avoidance dimensions do not differ significantly across the low and high resilience groups. (Table 8).

**Table 8**

Comparison of means of low and high resilience groups on dimensions of social problem solving

| Variable | Group | Mean | SD | df | t-value |
|---|---|---|---|---|---|
| Positive problem orientation | Low resilience. ( N = 108) | 2.33 | .65 | 209 | -6.323* |
| | High resilience. (N = 103) | 2.93 | .73 | | |
| Negative problem orientation | Low resilience. ( N = 108) | 1.97 | .80 | 209 | -1.204 |
| | High resilience. (N = 103) | 2.11 | .86 | | |
| Rational problem solving style | Low resilience. ( N = 108) | 2.16 | .70 | 209 | -5.184* |
| | High resilience. (N = 103) | 2.66 | .72 | | |
| Impulsivity style | Low resilience. ( N = 108) | 1.97 | .69 | 209 | .157 |
| | High resilience. (N = 103) | 1.95 | .69 | | |
| Avoidance style | Low resilience. ( N = 108) | 2.31 | .70 | 209 | .179 |
| | High resilience. (N = 103) | 2.29 | .89 | | |

* Significant at 0.01 level

## DISCUSSION

The results of the correlational analysis have proved that there is significant relationship between Resilience and Social Problem Solving skills in this sample of urban Indian adolescents. These findings are supported by earlier researches also on samples based outside India. Previous research on ascertaining traits of resilient individuals deduced that generally, resilient children have five attributes: (a) social competence, (b) problem-solving skills, (c) critical consciousness, (d) autonomy (Bernard, 1993, 1995), and (e) sense of purpose (Bernard, 1995). Social competence includes qualities such as empathy, caring, flexibility, communication skills, and a sense of humor (Bernard, 1993, 1995). Children who have social competence establish positive relationships with adults and peers helping them bond with their family, school and community.

Problem-solving skills incorporate the ability to think abstractly giving children the ability to generate alternate solutions for cognitive and social problems. Planning and resourcefulness in seeking help from others are two important problem-solving skills. Critical consciousness involves having an insightful awareness of structures of cruelty (e.g., be it from an alcoholic parent) and generating strategies in overcoming them. Autonomy is a person having a sense of his or her own identity, capability to act independently, and ability to exert some control over the environment. Finally, a sense of purpose, according to Bernard (1995), involves having goals, educational aspirations, and a belief in a bright future. ( Zolkoski S.M, Bullock L.M.,2012).

The second hypothesis has been validated partially as resilience is correlated positively and significantly with only two dimensions of social problem solving ability i.e. Positive Problem Orientation and Rational Problem Solving. Further support for these findings can be found in the book *Build Your Resilience* by psychotherapist Donald Robertson. He writes that the concept of 'Negative problem orientation' describes a set of attitudes that appear to be correlated with severe anxiety and depression. It is likely that 'Positive problem orientation' by contrast may describe a construct similar to psychological flexibility and resilience. (Robertson D.J, 2012). No significant correlation is obtained with the dimensions of Negative Problem Orientation, Impulsivity Style and Avoidance Style. Although slight negative correlation was obtained between resilience and impulsivity and avoidance style, it was not statistically significant. Yet, we can deduce a direction of the relationship of these constructs from these results.

The third hypothesis has also been validated as there is significant difference in the social problem solving abilities of the high resilience group and the low resilience group in this sample. The resilient adolescent has the capacity to deal with the obstacles which confront him successfully and at the same time he is able to focus on achieving his goals. A finding that has emerged from several studies is that resilient young people appear to be characterized by higher intelligence or problem solving skills than their non-resilient peers. (Fergusson & Lynskey, 1996; Herrenkohl et al., 1994; Kandel et al., 1988; Masten et al., 1988; Seifer, Sameroff, Baldwin, & Baldwin, 1992). Also, resilient children are notably different from non-resilient children in terms of having greater problem-solving, coping with stress, self-regulatory skill, and

self-esteem, as well as in receiving more active parental monitoring (Berman, 2007; Gilligan, 1999).

The fourth hypothesis has been proved partially as there is significant difference in the means of only the dimensions of Positive problem orientation and Rational problem solving. This corresponds to the results of the correlation analysis also and these findings can guide us in mapping and fostering resilience of Indian adolescents as well. Resilience embraces the ability of an individual to deal more effectively with stress and pressure (Steyn, 2006). Problem-solving skills, a higher IQ, abstract thinking, reflectivity, flexibility, and the ability to try alternatives indicate adaptability to stress. (Meichenbaum,2009) .Resilience training for adolescents all over the world involves teaching problem solving skills to them. Problem solving abilities have been linked to resilient children compared to their non-resilient peers (Heppner, P. P., & Hillerbrand, E. T. 1991, Nezu, A. M., Nezu, C. M., & Perri, M. G. 1989, Fergusson D, Lynskey M, 1996. Masten AS, Hubbard JJ, Gest SD, Tellegen A. 1988, Garmezy N, Ramirez M, Seifer R, Sameroff AJ, Baldwin CP, Baldwin A.1992) and have been identified as promoting resilient outcomes in a range of risk situations including poverty and abuse (Egeland B.1997), homelessness (Buckner JC, Mezzacappa E, Beardslee WR, 2003), cancer survivors and parents with a mental illness (Beardslee WR. 1989), and depression (Dumont M, Provost MA., 1999).

If one is problem free today, it does not mean it will always be this way. A positive outlook towards even the uncertainties and sudden adversities in life has to be taught as a skill to the young Indians. Both optimism and rationality are required to adapt best to the changed environment as with a negative emotional set it is not possible to accurately analyse the problem, attribute justified causation and plan a realistic action for the solution.

It's time that the fine old saying of 'Hoping for the best, but preparing for the worst' be applied consciously to the various life skills modules of the curriculum of all Indian schools. Of course, the interventions should be culture specific to the Indian scenario. As Nan Bahr writes that seeing resilience as a "competence" is a useful perspective because that means it is something that can be actively developed, taught, practised, demonstrated and deployed.( Bahr, N & Pendergast, D .2007 ). Resilience is now known as a dynamic construct and all efforts should be made by the school, parents and community to foster this in the Indian youth. Its been more than four decades since the strength- based interventions have proven to be extremely productive for adolescent issues and its time that even Indian adolescents get the benefit of these interventions rather than being treated as liabilities to all. Rather than lamenting the unfortunate developmental trajectories of these urban teen, it would be prudent to develop strength –based interventions based on problem solving training to foster resilience , which can be easily implemented at the school level.

## CONCLUSION

In conclusion, this study has validated the presence of social problem solving abilities in resilient adolescents of urban India. Perhaps fostering resilience and social problem solving abilities would ensure a mentally fit and hardy generation ahead.

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# Caregiver Burden in Learning Disability

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**ABSTRACT:**

Developmental Disorders interrupt normal development in childhood and involve significant handicaps, with onset before 18 years, which affect adaptive, self-help, cognitive and/or social skills. One of the most commonly occurring developmental disorders in normal school going children in India is Specific Learning Disability (3 % to 10%, Arun et al.,2013). The essential feature of Learning Disabilities is the presence of average to above average intelligence with large discrepancies between their abilities and specific areas of difficulty (DSM IV-TR, 2000). Parents play a crucial role in facilitating and maintaining gains in children with developmental disorders. Managing developmental disorders in children affects various aspects of the wellbeing of parents- the primary caregivers. This study focuses on the Quality of Life and Parenting Stress among parents whose children have Learning Disabilities. One hundred parents whose children were diagnosed with Learning Disability were involved in this study. The tools used were the World Health Organization Quality of Life Questionnaire (1996) and the Parenting Stress Scale by Judy. O. Berry (1995). Comparison with 100 parents whose children were normal was also studied and significant results were obtained. Gender differences in the experience of Quality of Life and Parenting Stress among parents whose children were diagnosed with Learning Disability was also seen. The study also explored the relationship between the Quality of Life and Parenting Stress experienced by parents whose children have Learning Disability. The relationship between the Quality of Life and Parenting Stress experienced by parents whose children are normal was also studied. The results of this study highlight the importance of integrating parental counselling and psycho-education for the effective management of Specific Learning Disability.

***Keywords:*** *Learning*

The term Learning Disability is used to describe a specific group of children, adolescents and adults who have problems in learning.

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Learning disorders are diagnosed when the individual's achievement on individually administered standardized tests in reading, mathematics or written expression is substantially below that expected for age, schooling and level of intelligence (Nakra, 1996). The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical or writing skills. The learning disabled child shows a discrepancy between achievement and intelligence.

The role of the family of the disabled child is vital. The family is thought to be the optimum environment for the development of disabled individuals. The addition of a disabled member usually results in substantial adjustments in the roles, norms, goals and communication patterns of the family. The level of acceptance of the disabled may vary from one family to the next. Frequently, the presence of a disabled child does precipitate a range of problems that may hinder the functioning and development of the family unit as well as individual members. Adjustment and problems are not static but change throughout the course of the family. Parents play the crucial role in facilitating and maintaining developmental gains in disabled children. The diagnosis of disability in a child is a traumatic event. Parental reactions to their child's disability are highly individualistic. The type and intensity of their response depends on how parents handle crisis situations in general, stability of the marital relationships and parental aspirations. Some of the common reactions include guilt, disappointment, shame, grief, anger and disbelief.

A child's growth and development depends heavily on the different aspects of his/her environment. Parents have an irreplaceable influence on their child's growing years. The Quality of Life and Stress experienced by parents in turn affects the psychological adjustment of the child. Also, rehabilitation programs usually focus only on the management of the child's difficulty. There is little or no emphasis on the parent, who constitutes an important part of the child's environment. Identifying and managing parental distress and other difficulties faced by them may help increase acceptance of the child's difficulty. Parental Quality of Life and Parenting Stress were explored to bring to light the various facets of parental wellbeing thus facilitating provision of a wholesome management plan for the child with Specific Learning Disability.

## METHODOLOGY

Ex-post-facto research design was used in this study. The independent variables were the presence of Specific Learning Disability and Gender. The dependent variables were Quality of Life and Parenting Stress.

Selection of the sample was carried out using the method of purposive sampling. Group A was the control group consisting of 100 parents (50 fathers and 50 mothers) whose children were normal. These children did not exhibit characteristics of Specific Learning Disability or any other developmental disorder as determined by a screening intake questionnaire. They were also matched for age and gender with the children in the Experimental group. Group B was an experimental group consisting of 100 parents (50 fathers and 50 mothers) whose children have

Specific Learning Disability. Parents bringing their children for the first consultation to a Pediatric hospital and who were not informed of their child's diagnosis were included in the sample. Parents whose children had the co-morbid condition of Attention Deficit Hyperactivity Disorder, disabling health conditions (such as epilepsy and asthma) and families where more than one member had a disability were excluded.

The tools used were the World Health Organization Quality of Life Questionnaire (WHOQOL-BREF, 1996) and the Parenting Stress Scale by Berry (1995).

## RESULTS AND DISCUSSION

Data were analysed using one-way ANOVA and Pearson coefficient of correlation.

**Table 1 represents the mean, SD and Critical Ratio on the WHOQOL-BREF for parents of Groups A and B**

| Groups | N | Mean | SD | CR |
|---|---|---|---|---|
| Group A | 100 | 100.84 | 11.61 | 3.82 |
| Group B | 100 | 95.3 | 11.68 | |

*p < 0.01: Significant at the 0.01 level

Results indicate that there is a significant difference in the quality of life of parents whose children have Specific Learning Disability and parents whose children are normal. Parents whose children have Specific Learning Disability have significantly lower Quality of Life. The parental burden that resulted from developmental disorders is greater than the burden associated with other disorders (Angold, 1998). The child's symptomatology and impairment increases the level of burden experienced by parents who are the primary caregivers.

Another interesting observation was that there were no gender differences in the experience of caregiver burden in learning disability. Both fathers and mothers obtained low Quality of Life scores. The presence of Specific Learning Disability adversely affects many areas of child psychosocial functioning including academic, social and emotional adjustment resulting in lowered parental quality of life.

**Table 2 represents the mean, SD and Critical Ratio on the Parental Stress Scale for parents of Groups A and B**

| Groups | N | Mean | SD | CR |
|---|---|---|---|---|
| Group A | 100 | 32.40 | 6.18 | 11.62 |
| Group B | 100 | 44.83 | 8.74 | |

*p < 0.01: Significant at the 0.01 level

Results indicate that parents whose children have Specific Learning Disability experience higher stress when compared to parents whose children are normal. The increased demands of the child with regard to parenting roles may be attributed to higher parental stress. Also, as Turnbull et al., (1993) reported, a major source of stress for parents involved their efforts to obtain appropriate educational services. Mothers and fathers experience similar levels of stress. No gender differences exist in the level of parental stress experienced by the experimental and control groups. Traditionally women are the primary caregivers for their children. Fathers' participation in childcare activities may be increasing (Snarey, 1993), indicating similar levels of stress with regard to parenting roles.

**Table 3 represents the mean and SD on the WHOQOL-BREF and the Parental Stress Scale and the Coefficient of Correlation between them as experienced by Group B**

| Group B | N | Mean | SD | r |
|---|---|---|---|---|
| Quality of Life | 100 | 95.30 | 11.68 | - 0.38 |
| Parental Stress | 100 | 44.83 | 8.74 | |

*p < 0.01: Significant at the 0.01 level

Results indicate that a significant negative relationship exists in the quality of life and stress experienced by parents whose children have Specific Learning Disability. As the level of parental stress increases, the quality of life of life decreases. This finding correlates with the Cognitive Model of Stress as proposed by Lazarus and Folkman in 1984. They define stress as 'a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing'. They have classified event perception as being either irrelevant or having no implications for the person's wellbeing, benign positive if it preserves the person's wellbeing and stressful when the person's wellbeing is affected. Therefore, parents whose children have Specific Learning Disability perceive their child's disability as stressful and thus experience lowered quality of life. No gender differences exist.

## CONCLUSIONS

Parents whose children have Specific Learning Disability experience low quality of life and high parenting stress. This study highlights that while managing Specific Learning Disability, parental aspects also need to be addressed to provide wholesome management for the child. Addressing and managing parental stress will also improve quality of life experienced. Both fathers and mothers of children with Specific Learning Disability should be given assistance to improve their wellbeing. A parental counselling module incorporated into the management program for Specific Learning Disability will be beneficial. Sessions addressing parental anxiety, depression, self-esteem, guilt or self-blame in addition to psycho-education focused on empowering parents to effectively manage their child with Learning Disability will be beneficial. Individualized parental counselling will increase parental acceptance of the child's difficulty, reduce parental stress and anxiety, enhance a positive approach while dealing with their child with Learning

Disability and help parents recognize personal strengths to aid their child's progress. This will play an important part in improving the quality of life of the parent and reducing parental stress, thus enhancing parental wellbeing. Improvement in parental wellbeing will in turn foster healthy interactions with their children who have Learning Disability. As a result, a healthy, stimulating environment created will facilitate progress of children with Learning Disability . Integration of Parental and Caregiver counselling in paediatric settings will enhance effective management of Learning Disability and other developmental disorders.

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# Limerence Causing Conflict in Relationship Between Mother-in-Law and Daughter-in-Law: A Study on Unhappiness in Family Relations and Broken Family

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**ABSTRACT:**

This paper examines the mother-in-law and daughter-in-law relationship and its causes and consequence for future of family. For this study, twenty five each, mothers-in-law and daughters-in-law were interviewed and interacted to know the status of the above relationship. From this study, it revealed that their relationship was suffering from various causes. Among these, limerence ( an emotional state of being love) was the prime. The son(her husband) was the limerent object to whom her mother(-in-law) was attached from his birth and she did not like to shift it to her wife(daughter-in-law). This was the main reason of their conflict which was creating psychological and social problems in their family life. This same gender discrimination was the burden of peaceful living. In this global era, it would be overcome through adjustment and sharing of their place of limerence.

***Keywords:*** *Limerence, mother-in-law and daughter-in-law relationship, same gender discrimination, unhappy family, son as limerent object.*

In-law relationships are unique one in every society. It is defined as a third party relationship by both a marriage and a blood relationship. Some anthropologists argued that in-law relationships are important to societies, both past and present, because they represent an alliance between two groups of blood relations (Wolfram 1987:12-18). In these cultures, in-law relationships are clearly defined and circumscribed by explicit institutional arrangements and prescribed and proscribed behaviors (Goetting 1990: 67-90). From Western ideology, however, we find that the husband-wife marital bond is the central family tie and supersedes claims of the extended family. Despite agreement about the rules of membership, the codes of conduct associated with in-law relationships remain nebulous. The actual interactions and sentiments assigned to these relationships are subject to individuals' definitions (Goetting 1990:67-90). Some patterns are restricted to relationships between parents-in-law and children-in-law.

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Other in-law relationships, such as that between sisters- or brothers-in-law, appear to be solely based on friendship or idiosyncratic relations (Finch 1989: 28:32). The research on in-law relationships has focused on assistance and support patterns. These patterns reflect the distinctive feature of in-law relations, which is that they are generally conducted through and, in a sense, for the sake of a third party (Finch 1989:28-32). Children-in-law primarily receive support from parents-in-law as indirect beneficiaries of parental aid to married children. Hence, the primary patterns of contact and support between children-in-law and their parents-in-law reflect customary patterns of parent-child relationships. In fact, the birth of the first child transforms the mother-in-law and daughter-in-law relationship into one involving significant support patterns. Daughter with preschool children needs and receives usually more help from both mothers and mothers-in-law. Mothers-in-law are more likely to give things, whereas mothers are more likely to do things. Daughters-in-law tends to seek help and advice more frequently from their mothers than from their mothers-in-law and are more likely to express ambivalence about help from their mothers-in-law(Fischer, 1983:263-290). Further, the flow of support for in-laws from the child generation to the parent generation is indirect and reflects patterns of gender differences associated with parental care. Parents are more likely to turn to daughters and, thereby, sons-in-law for help than to sons and daughters-in-law. However, help to the elderly, which does not usually entail financial support, is more restricted to services and help with household tasks and personal care (Powers, 1992:194-215, Kivett, 1992:228-234 and Schorr, 1980; 68-76). This type of support is primarily performed by daughters, not sons or sons-in-law. In fact, elderly parents prefer daughters as their caregivers. When daughters are not available geographically or absent in a family, parents turn to sons and daughters-in-law for help during illness and other causes (Powers, 1992: 194-215 and Kivett 1992: 228-234). There is also some evidence, however, that caring for mothers-in-law is perceived as more stressful and requiring more tasks than caring for a mother (Steinmetz 1988: 34-80).

So, the dynamics of the relationships between mother-in-law and daughter-in-law are very much significant in everyday conversation, popular cultural, jokes and television shows. But there have not been widely studies on this subject. A few studies (i.e. Denmark and Ahmed, 1989) explored that children were found to perceive greater interpersonal distance and have more negative attitudes towards mother-in-law than mothers. Stack(1974) focused in his study that the support pattern between in-laws and children was based on service and financial aid. There has been less empirical evaluation of relationships between in-laws and children because rarely available data and variation in in-laws relationship in different contexts. However, in-laws relationship is determined by happiness, stability and other social, cultural and economical functions in the family. In India, in most cases, in-laws relationship are either causing violence or harassment or torture against each other or it breaks the family relation through emergence of another household. The assumptions are made in general that it involves with revenge, insecurity, dominance and other psycho-social and cultural aspects among in-laws.

To study the dynamics of in-laws relationships, we might not focus our discussion on traditional aspects rather it would be highlighted two main aspects- (i) importance of psycho-social magnitude of mothering and motherhood and its expectation from off-spring and (ii) another one is limerence (being in love) – an emotional state yielded from mother and child attachment.

At first we would look that women are born naturally mothers with capacities, dispositions, and desire to nurture child(ren). Ideologically, construction of intensive mothering is inculcated three aspects – (i) mother as central care-giver, (ii) mother devotes "lavishing copious amounts of time, energy and materials resources on child", and (iii) 'mother regards mothering as more important than paid work'. So, mothering/motherhood involves with child-centred, expert guide, emotionally absorbing, labour- intensive and financially expensive. The mother and child relationship is highly emotional and physically dependent ( O'Reilly, 2004: 5-20). From mother's womb, attachment (Ainsworth & Bowlby, 1991: 331-341) and an ontological security bind mother and child together ( Giddens, 1991: 70-75). The mothering and motherhood as cultural practice turn towards emotional and social security to mother and her family. So, from pregnancy, mother is only care-giver to her child whose happiness indicates mother's happiness.

This mother-child dependent relationship forms an affectional bonding with each other. It is deeply rooted between two. But the child's bonding with his/her mother gradually reduces due to his/her changing emotional state, needs and demands matching with up-bringing process and emergent of other social network of relationships.

The emotional state is a feeling as state of limerence (being in love), a condition of cognitive obsession as well as mental activity(Tannov, 1999 : 20-50). This bonding state between two individuals is a desire for more than sex. It represents mother-child reciprocation through physical union creating the ecstatic and blissful condition for "the greatest happiness". Thus after birth a child, mother's limerence may begin and nurtures by appropriate condition and child becomes her object of a new limerent passion rather than her husband or any one. It transforms from one to another. The child is the limerent object to his/her mother. Affection and fondness have no "objective". They simply exist as feelings in which one disposes towards action to which receipt might or might not respond. In contrast, limerence demands return. Mother and son relationship balances of hopes and uncertainty. She dreams for her son's future that renews her family after getting marriage which strengthens their family tie. Simultaneously, she feels to be rejected by her son because her limerent object would be captured by another intimate one who is her daughter in law and she is his sexual partner.

From time immemorial, the relationship between mother-in-law and daughter-in-law has been unique. The authority, integrity, order-city, mutual understanding and compromises are key determinants of this relationship( Denmark and Ahmed, 1989: 1194). The son (her husband) is the focal point of this relationship. The in-laws relationships are generally affectionate,

understanding from in-laws, formal and strained relationship which are of lower quality and create distance between parties concerned. Many times, in-laws might be estrangement, leading to angry, outburst and even blocking of communication. Traditionally, financial related to dowry and other expected contributions from daughter's-in-law family leads to emotional estrangement and strained relationships, Daughter-in-law usually faces threats and she is fearful about unwanted interference of the mother-in-law. On the other part, mother's-in-law shows over possessiveness, and creates tension because she feels that her son's love and attention would be exclusively claimed by an outsider(daughter-in-law). Her reluctance and resistance towards financial and administrative control of the family creates critical situations in their family. Consequently, it yields a threat in the mother's mind so that she reacts in a negative manner, and leading to hurt feeling in daughter-in-law(J Murickan, 2002: 100:110). Thus after few months to years, it breaks due to strife between mother in law and daughter-in-law which is the cause of division of family ( Rossi and Rossi, 1990: 233).

In India when a man marries he gets a wife, where as a woman gets a whole family, whose whims and fancies she has to pander to. Through this, the mother-in-law gets as new daughter and the daughter-in-law, a new mother. But this relationship does not become healthy mostly according to the desire of both sides. Both of them finger to each other for their bitterness in their relationship. The daughter-in-law is possessive that the mother in law might have about her son(her husband). The mother tends to feel insecure and fears to loose her attachment/bonding with her son because her son would no longer need her and his wife would fulfill his every need. The emotional commitment gradually pushes her into some psychological disorders to physical suffering. Nevertheless, she tries to feel insult when the young couple goes out leaving her alone at home. In such cases, the mother starts demanding attention from her son and the wife in turn starts pestering her husband for separate establishment away from the mother. This is the fact that occurs in everyday family life almost in every family. It causes the truncated family relationship in our society. In words, role expectation and role performance are the causes of conflict and the son(her husband) is limerent object is central point of this conflict.

The paper would examine how limerence was central point of this conflict between mother-in-law and daughter-in-law and what would be a remedial strategy to rebuild this relationship towards a healthy state.

**METHODS;**

The research design for this study was simple exploratory study. The threesome relationships of mother-in-law, son(her husband) and daughter-in-law were not determined by social, educational, economical and cultural background. The son was the centrifocal parameter who used to balance the relationships and he was the limerent object to both of them. Further, limerence never depends on any socio-religious, educational and economical background of

anyone involved with this state. In this study, the mother's demanded her affection towards her son as her birth right and daughter-in-law(his wife) claims as her conjugal right for rest of the life. That's why, the researcher ignored consciously the personal background of informants in this study. The mother-in-law and daughter-in-law relationship was generally a negative to all regardless of their any personal background. Almost all of the families used to suffer from the crisis in poor relation representation.

Thus, twenty five mothers-in-law and equal number of daughters-in-law were randomly selected without considering their social, economical and other background from Kolkata, only metro city of eastern India. This urban population had been settled themselves in new emergent urban housing colony. Some of them were not living together with mother-in-law or daughter-in-law. But they were connected with each other daily. They had been in an in-law relationship for between one and ten years. For the purpose of this study, they were interviewed separately through unstructured interview schedule. They shared their different experiences of being either mother-in-law or daughter-in-law. The qualitative data included the dynamics of their relationship, its cause and effects in everyday life. How their power and authority, dominance, non-judgmental attitude, adjustment problems and limerence were impacted for happiness and disturbance in their relationships. The interviews were also conducted with ten fathers-in-law and fifteen sons(her husband's) were also shared their opinion regarding their relational representation to their mothers and also to their wives. The interaction and observation were used to collect information. The interviews were recorded and then transcribed.

## RESULT AND DISCUSSION:

### *Dynamics of mother-in-law and daughter-in-law's relationship:*

From analysis of transcribed interviews, we find that the many faceted of discord predominated daughters-in-law speech about mothers-in-law. Seventeen of mothers-in-law/daughters-in-law relationship, as described by daughters-in-law was "strained", "uncomfortable", "infuriating". Fifteen mothers-in-law described being in the company of a daughter-in-law as "tensed", uneasy", "uncomfortable". Five mothers-in-law felt a daughter-in-law was "a precious friend' or "as good as a daughter". Three mothers-in-law admitted to hating a daughter-in-law. Out of ten fathers-in-law, seven of them said a daughter-in-law was "nice enough" and their relationship was "all right". Three of them expressed hostility – primarily in defense of their wives, who suffered in their mother-in-law/daughter-in-law relationship.

The interviews with mothers-in-laws mentioned that about 10% of them considered their daughters-in-law as enemy and 29% of them considered as only in-law. When the questions asked regarding joint sharing, the mothers-in-law replied, 42% of their daughters-in-law never asked for advice and 55% of them asked sometimes for advice. Here, we also recorded the mother and son relationship after their marriage. Of them, 23% son's relationships were gotten

worse and 51% of their relationship was in static position. But in case of rest 20%, it was showed better than before their marriage. Gradually, the mothers-in-law faced trouble in relationships with their daughters-in-law. Of them, 47% shared that there was no changed, while 20% of them shared that it was gotten worse day by day.

Another important aspect of relationship was shared by mothers-in-law that daughter-in-law(40%) used to criticize them to their sons(their husbands) and 15% of them criticized regarding their style of mothering. They felt angry towards their daughters-in-law because 20% of them were kept apart from grandchildren. When they were asked about spare of their leisure specially during holidays, 13% of these mothers-in-law replied that it was just impossible. Thereafter, 10% of them opined that they did not like daughters-in-law at all and further, 14% of them told that they liked them sometimes. Twenty percent of these mothers-in-law shared that their daughters-in-law were not suitable/matched with their sons. Last of all, they made some criticisms about their daughters-in-law. Among them, 20% shared that their daughters-in-law tried to keep their sons away from their mother, according to them (11%), their daughters-in-law were not good housekeeper, 10% of them said that they spent too much money. Finally, they shared that majority (58%) of them would like to stay far away from their sons and daughters-in-law.

***Daughters'-in- law experiences and opinions towards their mothers'-in-law- their behaviour and image in their relations :***

A large daughters-in-law discourse, centred around the mothers-in-law, was on the mothers'-in-law failure of recognition or validation for aspects of their identity, they themselves valued highly. In this context, they opined that mothers-in-law showed preference for their son's career, and expected the daughters-in-law to sacrifice her career to that of her husband.

According to one thirty two years old daughter-in-law, " I love my mother-in-law, but I can't depend on her support. She'll always be biased towards my husband's career. If she was my mother, I'd fight back. But fighting a mother-in-law over this something I cannot win. She may be feminist, but she is a mother first. She wants her son to be happy".

A twenty six years old woman(daughter-in-law) shared that her mother-in-law ( a school teacher), "was generally supportive of women and on the surface, all for equally at home, but when I told her about a new job offer, she did not support it. I was really shocked by her comments. She told that it would not be possible to her because of commuting problem and her absence from household would be a difficulty. Thereafter, I cannot trust her with this stuff".

There was another common view was intrusion – either on the ground that the mother-in-law seemed to "baby" the husband, or on the grounds that the mother-in-law presented herself as weak and needed to be "mothered" by the son.

A daughter-in-law of about 36 years old and a housewife explored, "She(mother-in-law) phones in the morning when we were in bed, and she says how sorry she is to disturb us, but she had to make sure he got back safely from his business trip. She does not see that he is a growing man, she does not believe he can be all right without her."

In our study, one daughter-in-law said, "She expects him to come round late at night even to change a light bulb. She wants him at her beck and call"

The magnitude of mother and son relationships would be strained when a daughter-in-law aged about 40 years and a high school teacher who lived with her husband and only daughter in her parental house discussed her problem relating to her mother-in-law. She shared, "I had taken this decision due to my mother's-in-law attitude towards me. She used to try to make separation between me and my husband. She was very much angry because our marriage was of our choice(love marriage). She counseled her son to dissolve our relationship and for this, she offered rewards to her son. She pressured him to stay only with her. Initially, when I took this decision, my husband tried to convince me that it would not be right thing to live her parents. He told me that after some years, it would be resolved. Anyway, my mother-in-law usually visits us in any occasion. But her behaviour towards her son does not change. She usually creates scene in gathering and this is intolerable".

Daughters–in-law also critically viewed their mother-in-law in the context of her involvement with housework and child care. Majority of the mothers-in-law used to advise their daughters-in-law for housework and child care. Their role was an instructor while they did not come to assist. Practically, it was the basic difference between mother-in-law and mother according to the daughters-in-law. They were non-supportive and non-negotiable when daughters-in-law did not any wrong and they shared their experiences in this connection.

One daughter-in-law in this study shared, " When I was busy to carry out my household duty, my baby was crying. So, I left my house work and took care of my baby. But my mother-in-law did not co-operate. On the other hand, she was shouting for her tea."

***Sons' views as central figure of mother-in-law and daughter-in-law relationship:***

Sons are the central point of building up of this mother-in-law and daughter-in-law relationship. He has respect and is affectionate with his mother. Before his marriage, his mother is his sincere partner of his every joy and sorrow. On the other part, after getting marriage, he gets her new partner for his whole and he renews his family. His wife is not only his sexual partner. She is also his friend and part and parcel of his every prospect. She also is his co-decision maker. But most them shared that they did not interfere in this conflict. They(sons) had no choice and preference. They did not want to face any conspiracy in this connection. They shared that

everyone had particularly special role and importance. Keeping the peace and harmony of the family, they should adjust and compromise.

A son of about 35 years old shared another story of his unhappiness with his mother. His mother was widower and his father died when he was a 5 years child. She brings him facing social and economical hardship. He was an educated and a public servant with good position. His mother was always with him. After some years of his job, he got married according to her mother's choice. But the problem was started after 3 months of marriage. Lastly, I divorced her with one and half years. He shared his relational aspect that his mother was jealous and she always tried to him within her grip. She did not allow passing a happy conjugal relationship. She brought her daughter-in-law to only take household care. "I was indifferent and never I like to hurt my mother because for her dedication I stood here. But being mother she did not compromise with my future happiness."

***Mothers(-in-law) attitude and behavior in relations to their sons and daughters-in-law : Sons as limerenent object of the mothers:***

After birth of her son, a mother is delighted supremely with "the pleasure that makes life worth living" and the experience of motherhood takes the other things more dying. Her will power makes her delightful to revolt anything in this planet. Thus a child becomes limerent object(LO) to his mother for whom she was distracted from her happiness and hence, child was central point of attention and concern. Her son as LO is being usually crystallized by mental events in which she feels attractive towards her son. It makes her blind of loving to him. Affectional bonding with her son makes him as stimuli in her daily life and she builds up her immediate association with him. Her thoughts encircles for welfare of him. This is a "moment of consummation" which yields a climax of commitment between two. Any change of this reciprocation might bring a risk of premature self-disclosure. The interplay is delicate, with the reactions of each person inextricably bound to the behavious of the other(Tannov, 1999: 36-45). It gives birth of fear of rejection, hope for resolution of sons' relations with their daughters-in-law and they are very much jealous considering the change in body language of their sons after their marriage and it is due to their daughters-in-law as new limerent object to their sons.

Thus, a middle aged mother (in-law) confronted "To day my son is grown and I remember when he was a baby boomer. He was an adorable child. Every one commented. I was offered a service with good package. But I rejected because I did not leave him alone. I dreamt to raise him without any difficulty. I felt for my decision of joining service would push him a loneness state. But now he has changed him due to his wife. His wife misguides him. She did not want my son comes to me and to be touched with me."

***Relationships between two(mother-in-law and daughter-in-law) in a competitive nature ;***

The root of this relationship problem lies in women's competitive nature. There are two women in love with same man. This is the conflict of limerent object. Mother's affectional bonding; and wife's love and sex relations are parallel in these relationships. However, if a mother-in-law understands that she will always have a special place in her son's heart, then she can enjoy this younger woman as a friend with new things to teach her and who can in turn learn from her wisdom and life experience which requires friendship with time, space and boundaries.

But many daughters-in-law viewed that whole concept of mother-in-law as a betrayal to their own mothers-perceiving a mother-in-law to be a stepmother trying to replace their primary relationship. Thinking of their personal insecurity was another cause of conflict

One mother-in-law aged about 55 years expressed her limerence to her son which was distracted by her daughter-in-law. In her words, "My son was very much dependent and caring to me. He used to regularly share his every state of joys and sorrows. We used to take food altogether and used to go to shopping and usually we attended relatives in any occasion. He was very much affectionate to her younger sister. But after some years of his marriage, he forgets all and he uses to deny. His wife is now all. Even, he takes food separately with his wife and he shows his anger when I ask him for anything. He uses to consult everything with his wife. I do not believe that he would change like this. I feel sorrow when I reminiscence his acts from childhood to before his marriage. Now my son and daughter-in-law said that I have been suffering from psychological problem."

Thereafter, the interview was recorded separately from her son and daughter-in-law. Her son expressed, "My mother does not like to leave me to do anything according to our own selves. She is dominant in nature from my childhood and a psychological patient. She behaves rudely with my wife." Daughter-n-law said, "Her interference in our lives is disgusting. She does not know how to be respected. She thinks that her so is till a baby".

***Effects of limerence in threesome relationships of mother-in-law – son(her husbad) – daughter-in-law :***

'Women are not born, but made'. The men's and women's bahaviour is ingrained, reflecting innate and essential differences between the sexes. The anatomical and physiological characterizes signifies maleness and femaleness( Beauvoir, 2011: 3-51). Gender constructs socially masculinity and feminity which are defined by social, cultural and psychological attributes in a particular society at a particular time. Thus gendering and gender practices in our society underpin a particular gender system of male dominance and discrimination. This system exists in relation to social and economic aspects as social whole (totality). These are interwined through two material processes - production and reproduction. Thus production and reproduction

relations are the cause of gender baisedness and also gender discrimination (Engels, 1948: 38-57) because the right to property and emergence of marriage institution transform the women as men's property. The Female lives are being trapped within the realm of reproduction with social scale and domestic duties. They are trained to perform all above duties through their different stages- daughter, wife, mother and so forth (Wadly, 1988: 21-23). In their life stages, motherhood as cultural practice(Rich, 1996 : 8-20) is revered as a moral, religion and even artistic deal. It brings family acceptance and emotional well-being. Motherhood is personal fulfillment of womanhood as well as biological achievement of a lifelong promise. From this stage of life, limerence shifts from husband to her child(ren). They use to dream for a new future gaol in their life. In fact, the gender preference in Indian society adds important value to male child because a male child is parental future security. So, the expectation and dependency towards male is high in particular, while female child as their(mothers) replica as guest in their parental family. It cultivates a same gender competition among women which we find in mother-in-law and daughter-in-law relationships. Both of them are dependent of male as son(her husband). Their lives are surrounded by males in different roles.

Mother and son are limerent with each other. Mother wants to keep her limerent object(son) intact. She does not accept of shifting of it or she does not allow whole hearted the entrance of other in this state. But her son shifts her limerent object after his marriage to his wife (daughter-in-law) who is also his sexual partner. This shifting is the cause of conflict and same gender discrimination in mother-in-law and daughter-in-law relationships. This alteration of limerent object brings changes in mother's attitude and behavior in relation to her emotional state with feeling of insecurity, fear of rejection and so forth. It is obvious according to the social and psychological characteristics of limerence. This same gender competitiveness causes maladjustment and non-negotiable relationships between mother-in-law and daughter-in-law. That's why, daughter-in-law shows negligence or avoidance towards her mother-in-law. This poor relational representation affected variously in our study. This study revealed that about 56% of them lived separately while they were in the same city within a distance of hardly within 5-7 km. Twenty percent lived together, but mothers-in-law and daughter-in-law did not interact with each other. About 12% of them(daughters-in-law) filed for divorce because their husbands (their son) were supporting their mothers(-in-law) and they had to force their wife to obey the interference as well as dominance of their mothers(-in-law).

The shifting of limerent object affected the mental health of mothers(-in-law) adversely because majority of them had been suffering from high blood pressure, blood sugar, gastric problems and cardiovascular problems, etc. Interestingly, as it might be considered as superstition, the mothers(-in-law) had been praying to their transcend 'God' to get back to her son from the grip of their daughters-in-law. Their sons attachment to there is considered as grip to them. But on the other part, daughters-in-law (about 48%) were in mental disturbance. But they replied that

behavior and attitude of their mothers-in-law was just vague and it was their inferiority complex. They thought that mothers-in-law should come out from this stage.

## CONCLUSION :

Limerence has crucial role in human relations and it is the source of living together in family as well as in particular society. The human beings regardless of their gender are tied up only limerence ( emotional state of being in love). Their everyday acts of living is a reflection of limerence because everybody is in their functions to society his/her limerent object. It might be considered as source of inspiration attached to their limerent objects. This emotional state does not include sexual act between the partners. Particularly, it might be a final stage of sexual act sometimes (between lovers/husband-wife/others).

Thus, mother-son/child relationships bind them together by limerence from his birth. Mother's happiness is determined by her son's happiness. She nurtures him for his up-bringing with care and attention. She dreams his future and future relationships with him for her safety and security in elderly life.

Mother always binds his son in a nuptial relationship by marriage of her son. She gets her new friend and primarily she (mother-in-law) enjoys that her son would be secured at the time of her absence. But the close proximity of relationships between son and daughter-in-law breaks her emotional state and she fears of rejection by her limerent object (son). So, she tries to control her son's with arrogant attitude and domination and other acts towards her daughter-in-law. She does do some acts by which she would be capable to break their(son and daughter-in-law) closeness and affection. She forgets to remember that her son and daughter-in-law is limerent object with each other and they are also sexual partner. This is central point of disturbance between two. It is being shed with limerence only.

In this study, it had been proved that the limerence is the only prime factor of unhappy mother-in-law and daughter-in-law relationships. The same gender discrimination due to this limerence encircles generation after generation. The women shifts their stages of status from daughter to mother to wife to mother-in-law (grandmother). But they keep intact their limerence with their sons. The study revealed that mothers-in-law were the main responsible factor of their relational disturbance. They used to finger towards daughters-in-law. Thus, their mental illness/psychological problems lead them to a critical elderly life. They used to suffer from various lifestyle diseases. They used to live alone and their limerence had broken their family life in a truncated relationship. So, everybody should understand this state of limerence. They should learn to adjust with their shifting of limerent object as a psychological need which fulfills social needs through happy relationship. Otherwise, it would not never change its dynamics. Once, woman was a victim of this state, when she was wife. But when she becomes mother-in-law, she practices it to victim other of her gender. Further, the above state of limerence may explain with

the help of Treisman's Theory of Vomiting(Treisman, 1977: 493-95). It explores that vomiting and malaise are part of an early defense and warning system inappropriate in the case of motion, but lifesaving in of toxin ingestion. So, it is that motion of sickness is an accident by-product of the organism's response to certain head and eye moments that occur in the case of food poisoning, but unfortunately, also in the case of certain types of theorizing. It conjectures about the "survival value". This relationship is the same with postulate of this theory of vomiting

Equality and justice towards women would be accelerated through women's co-operation and support because in our patriarchy male domination would not erase forever. Further, feminism teaches to come out from male domination, but anti feminism directs woman without man is just impossible.

Finally, there is need of counseling to the mothers-in-law and daughters-in-law for promotion of a healthy family for their own survival.

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# Subjective Well-being and Religiosity: A study of Optimists and Pessimists

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**ABSTRACT:**

Pessimist Individuals see difficulty in every opportunity where as Optimists see opportunity in every difficulty. Taking into consideration these characteristics of Optimism and Pessimism, this study was designed to conduct on the samples of the Optimist and Pessimist subjects in order to ascertain the influence of Religiosity on Subjective Well-being. Using Purposive Sampling technique, 50 Optimist and 50 Pessimist Post Graduate students were selected with the help of Life Orientation Test–Revised (LOT-R) developed by Scheier, Carver, & Bridges, (1994). Religiosity and Subjective Well-being among Optimists and Pessimists were assessed on the basis of scores on Religiosity Scale developed by Deka and Broota, (1985) and Subjective Well-being Inventory (SUBI) developed by Sell and Nagpal (1992). Data was analyzed with the help of Simple Linear Regression. The first finding revealed that Religiosity appeared as a significant predictor of Subjective well-being among Optimists. It means that there is a significant positive correlation 'R'= .774 between Religiosity and Subjective Well-being among Optimists whereas, the second finding also revealed that Religiosity appeared as a significant predictor of Subjective Well-being among Pessimists. This indicates that there is also a significant positive correlation 'R'= .497 between Religiosity and Subjective Well-being among Pessimists. Since, the Optimists and Pessimists were found in maintaining good Subjective Well-being but the value of 'R' in case of Optimists was found to be much higher. So as on the basis of the obtained results , it is discussed that the Optimists look into more favorable side in the face of events and anticipate best possible outcomes in their favor as compared to the Pessimist counterpart. It is suggested that one has to make efforts to be Optimist rather than Pessimist to conquer challenges in their life.

***Keywords:*** *Subjective Well-being, Religiosity, Optimists, and Pessimists.*

Optimism is a thinking based trait of an individual that can lead to go ahead by preserving a mindset which could be related with one's attaining success in life. Optimists are therefore able to achieve success in most of their pursuits.

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While Pessimistic people are left behind and have few accomplishments. It is rather infrequently true that a Pessimistic person is also successful, happy, and have fairly good accomplishments. But they often show the tendency of withdrawn low risk taking behaviour and are not always mentally prepared and assertive towards the achievements. They try to succeed but live with a conflicting state of mindset. It is important to mention that an individual doesn't attain success miraculously rather it depends upon several factors which might be reasonably responsible for one's attaining success. Optimism is one such factor. Setbacks and bruises are left behind by an optimistic individual. Failures seem to be hardly possible, if an individual learns and decides to bounce back from such obstacles and prefers to remain undefeated. He strives to strengthen his Optimism and makes his mind to endure every test in life. The expectation of being more successful makes them work harder to achieve their goals. That is why Optimists are more successful at what they do. Choosing to focus on actively finding solutions instead of what is going wrong and with this vision, they are able to conquer and win. The memories of their success drive them forward in difficult times. It is much easier to think of the possibilities, than to wallow in the negative ones. Once the Optimistic mindset is built, an individual will rediscover the God that lives within and his path i.e. Religiosity and will start a life with renewed passion and earnest resolve. In this way, we can imagine how important is to imbibe an Optimistic mindset.

It seemed important to conduct a study after looking at the contribution of Optimism towards an individual's success. And if an individual is Optimist rather than a Pessimist, it is obvious that he may be possessing better Subjective Well-being and may be directed towards the path of God. Scheier and Carver (1993); Scheier, Weintraub, & Carver, (1986), suggested that optimists report higher SWB because they manage critical life situations better than pessimists do. That is, optimists tend to deal with the source of the stress using a problem-focused coping strategy, whereas pessimists tend to avoid directly confronting the problem itself and use an emotion-focused coping strategy. Optimism is understood to have a strong link with religion (Sethi & Seligman 1993, Mattis, Fontenot & Hatcher-Kay 2003).

Optimism, Religiosity, and Subjective Well-being are in combination responsible for the grand success of an individual. So a need aroused to see, Is optimistic mindset rather than a Pessimistic mindset in a real sense a factor contributing to religiosity and Subjective Well-being?

## SUBJECTIVE WELL-BEING

Subjective well-being describes people's evaluations concerning to their lives, including both affective and cognitive dimensions (Diener, Lucas, & Oishi, 2002). The affective dimension relates one's experiences of positive affect - joy, happiness, and pride where as the negative affect such as sadness, stress, and guilt. The cognitive dimension refers to people's satisfaction in life (Diener, Suh, Lucas, & Smith, 1999).

Subjective Well-being has been found to be correlated with optimism (Scheier & Carver, 1985), self-esteem (Wilson, 1967), and control beliefs (Lachman & Weaver, 1998).
A recent meta-analysis of optimism supported by earlier findings indicate that optimism is positively correlated with life satisfaction, happiness, psychological and physical well-being and negatively correlated with depression and anxiety (Khazen & Steven).

The relationship between optimism and subjective well-being seem to vary in adults of different ages, but divergently that cause different forms of optimism. A central tenet of the compensatory theories that account for how overall well-being may remain stable as individuals age is that the importance of divergent domains may shift (for example, the model of Selective Optimization with Compensation: Baltes & Baltes, 1990).

## RELIGIOSITY

Religiosity refers to a broad set of beliefs and behaviors centering on the sacred (Hood, Hill, & Spilka, 2009). Religiosity, in its broadest sense, is a comprehensive Sociological term used to refer to the numerous aspects of religious activity, dedication, and belief. Another term that would work equally well, though less used, is religiousness. In its narrowest sense, religiosity deals with how religious a person is, and less with how a person is religious.
Park & Folkman (1997) viewed that holding spiritual or religious beliefs can increase people's likelihood of finding positive meaning in life. Positive emotions not only to feel good but balancing positive and negative emotions can contribute to one's perception of life satisfaction (Hayes & Weathington, 2007).

A growing body of research suggests that greater religious involvement is associated with higher levels of subjective well-being (Ellison & Henderson, 2011). For example, relative to their less religious counterparts, more religious individuals are happier (Myers, 2000), less distressed and anxious (Ellison & Levin, 1998), and more satisfied in life (Hackney & Sanders, 2003). Beyond cross-sectional associations, religiosity predicts improvements of well-being over periods of months and even years, such as alleviating depressive symptoms (McIntosh, Poulin, Silver, & Holman, 2011), fostering greater optimism (Ai, Peterson, Bolling, & Koenig, 2002), and increasing life satisfaction (Koenig & Vaillant, 2009).

## OPTIMISM AND PESSIMISM

Carver & Scheier (1990) "Optimists, by definition, are people with favorable expectations about the future. Such expectations should make success on a given problem seem more likely and should thereby promote continued problem-solving efforts, resulting in better outcomes."

Scheier, Carver and Bridges, (2001), tell us about the 'optimistic advantage' which is due to differences in the manner in which optimists and pessimists cope with the difficulties they confront. So as the optimists seem intent on facing problems head-on, taking active and constructive steps to solve their problems; pessimists are more likely to postpone their effort to attain their goals.

Optimists believe that positive events are more stable and frequent than negative ones. They think that they can avoid problems on their own in daily life and prevent them from happening, and in result of it they are prepared to cope with stressful situations more successfully than pessimists. (Aspinwall, et al., 2001, Peterson and De Avila, 1995)

Optimism is understood to have a strong link with religion (Sethi & Seligman 1993, Mattis, Fontenot & Hatcher-Kay 2003). Tiger (1979) argues that religion developed as a response to fulfilling a biological need for people to be optimistic with religious thought mirroring that of

optimism in its certainty. To have faith in religion there requires a certain amount of optimism to maintain the belief that a superior being will protect and save them, reserving a special place in the afterlife for them.

Individuals with more positive self-illusions, including unrealistically positive self-perceptions or overly optimistic views of the future, not only have higher SWB but other qualities such as caring for others and the ability to engage in productive work (Taylor & Brown, 1994).

An individual's disposition, including optimism, is an important predictor of well-being, so too is the social aspect of one's life (Finch & Graziano, 2001).

## AIM OF THE STUDY

The present study is designed to determine the influence of Religiosity on Subjective Well-being among Optimists and Pessimists. In the light of these objectives the following Research Questions are raised to be investigated.

- Is there any influence of Religiosity on Subjective Well-being among Optimists?
- Is there any influence of Religiosity on Subjective Well-being among Pessimists?

## METHODOLOGY

### Sample

The participants of this study were selected by means of purposive sampling technique from the Post Graduate classes of different department of A.M.U. Optimists and Pessimists were identified by Life Orientation Test- Revised (LOT-R) developed by Scheier, Carver, and Bridges (1994). The total sample consisted of 100 participants with equal number of Optimists (n=50) and Pessimists (n=50)

### Tools

*Religiosity scale*

To measure the Religiosity among Optimists and Pessimists, The Religiosity scale developed by Deka and Broota (1985) was used. The scale consisted of 44 items, out of which 25 are positively keyed and 19 are negatively keyed. The presence of both positively and negatively worded items included in the test was to avoid the tendency of the respondent to develop a response set that might occur, were the items only positive or only negative. In this way the adequacy of the response given by the participants could be established. The reliability coefficient for the religiosity scale was 0.96 for an adult sample of subjects.

*Subjective Well-being Inventory (SUBI)*

Subjective Well-being Inventory developed by Sell and Nagpal (1992) was used. It is a self reported questionnaire consisting of 40 items designed to measure an individual's mental status regarding overall feeling about life. These 40 items are divided into eleven factorial dimensions

namely- Positive affect, Expectation-Achievement congruence, confidence in coping, Transcendence, Family group support, Social support, Primary group concern, Inadequate mental mastery, Perceived ill-health, Deficiency in social contacts and General wellbeing negative affect. For positive items, score is 3, 2 and 1 respectively and vice-versa for the negative items. The sum of all 40 items gives overall Subjective Wellbeing score. Higher score indicates better Subjective Well Being and vice-versa. The scale has been found to have high inter-rater, inter-scorer, and test-retest reliability and has proved its validity through many experiments (Grandall, 1976; Huisman. 1981) and was therefore considered appropriate for this study

*Question-wise Scoring*

In 19 out of 40 questions (questions 1-15, 21-23 and 28)- Value 3 was given if the respondent has selected the category 1 (very much); Value 2 was given if the respondent has selected the category 2 (to some extent); Value 1 was given to category 3 (not so much). In the remaining 21 questions (questions 16-20, 24-27 and 29-40)- Value 1 was given if the respondent has selected the category 1 (very much); Value 2 was given if the respondent has selected the category 2 (to some extent); Value 3 was given to category 3 (not so much). However, for questions 14, 27 and 29, if the respondent has selected category 4, value 0 (zero) was given. All the values were added to get the total score. The maximum score on the test is 120. Higher the score, higher is the Subjective Well Being of a person. The total score can be interpreted summarily in the light of three broad score ranges: 40-60, 61-80 and 81-120 to have an overall picture of the well being status. The mean score on normal adult Indian samples is 90.8 with standard deviation of 9.2.

*Life Orientation Test-Revised (LOT-R)*

Life Orientation Test-Revised (LOT-R) developed by Scheier, Carver, and Bridges (1994) was used to identify the Optimists and Pessimists. This Scale is a 10-item measure of Optimism versus Pessimism. Out of which 3 items measure Optimism, 3 items measure Pessimism, and 4 items serve as fillers. It is a 4-point Likert Scale, 0= Strongly disagree, 1= Disagree, 2= Neutral, 3= Agree, and 4= Strongly agree.

LOT-R is a revised version of the original LOT (Scheier & Carver, 1992). The original LOT had 12 items: 4 worded positively, 4 worded negatively and 4 fillers.

Items 3, 7,and 9 are reverse scored (or scored separately as a Pessimism measure). Items 2, 5, 6, and 8 are fillers and should not be scored.

Scheier, Carver and Bridges report an internal reliability coefficient of .78 for an undergraduate sample.

## PROCEDURE

The participants selected gave their consent to be the part of the present study. They were told about the purpose of the study. After that, LOT-R developed by Scheier, Carver, and Bridges (1994) was administered on 150 participants in order to identify the Optimists and Pessimists. In this way 100 participants were finally identified as Optimists (n= 50) and Pessimists (n=50). Religiosity scale and Subjective Well-being Inventory (SUBI) were administered on participants

to asses Religiosity and subjective Well-being. After collection of the data, Simple Linear Regression was used to analyze the obtained data.

## RESULTS AND DISCUSSION

**Table 1: Represents Linear Regression Analysis to indicate relationship between Religiosity and Subjective Well-being of Optimists.**

| Model Summary | | | | |
|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Change Statistics R Square Change |
| 1 | .774 | .599 | .590 | .599 |
| a. Predictors: (Constant), Religiosity Optimists | | | | |

The above table shows Simple Linear Regression analysis of Religiosity, it showed that Religiosity appeared as significant predictor of Subjective Well-being. It was found that Religiosity (Predictor) emerged to influenced significantly the youths' Subjective Well-being (Criterion). This table shows the model summary, which indicates one predictor of the model. The correlation was found to be R= .774. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore the original covariance, the magnitude of independent variable which contributed to the dependent variable (Subjective Well-being) came out as 59.9%.

**Table 2: Represents the details of Coefficients between Religiosity and Subjective Well-being of Optimists.**

| **Coefficients** | | | | | | |
|---|---|---|---|---|---|---|
| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. |
| | | B | Std. Error | Beta | | |
| 1 | (Constant) | -37.091 | 16.980 | | -2.184 | .034 |
| | Religiosity Optimists | .697 | .082 | .774 | 8.463 | .000 |
| a. Dependent Variable: Subjective Well-being Optimists | | | | | | |

The above table clearly shows that Religiosity, the predictor variable influences Subjective Well-being (Criterion). The Statistical value given in the table was found significant for above mentioned predictor that is Religiosity indicating a relationship between predictor and criterion variable Subjective Well-being.

The value of Partial Correlation is r = .774, therefore predictor significantly influenced the degree of Well-being, this finding indicates that Religiosity appeared as a significant factor of Subjective Well-being among Optimists. The table indicates a significant positive correlation exists between Religiosity and Subjective Well-being among Optimists. It means that when

Religiosity increases Subjective Well-being also increases and when Religiosity decreases Subjective Well-being also decreases.

Research suggests that greater religious involvement is associated with higher levels of subjective well-being (Ellison & Henderson, 2011). For example, relative to their less religious counterparts, more religious individuals are happier (Myers, 2000), less distressed and anxious (Ellison & Levin, 1998), and more satisfied in life (Hackney & Sanders, 2003).

Scheier and Carver, (1985) found that Optimistic individuals are positive about events they face in daily life. In the research carried out regarding this perspective, positive correlations have been found between Optimism and physical/mental well-being.

Subjective well-being has also been found to be correlated with optimism (Scheier & Carver, 1985), self-esteem (Wilson, 1967), and control beliefs (Lachman & Weaver, 1998).
Individuals with more positive self-illusions, including unrealistically positive self-perceptions or overly optimistic views of the future, not only have higher SWB but other qualities such as caring for others and the ability to engage in productive work (Taylor & Brown, 1994).

In conclusion of the findings of above studies, we may say that Optimists are more religious because they have positive outlook on everything in their life and Religiosity is intimately associated with Subjective Well-being. This indicates that if an individual is Optimistic and highly religious, this Religiosity and Optimism can influence his Subjective Well-being in a positive manner.

**Table 3: Represents Linear Regression Analysis to find out relationship between Religiosity and Subjective Well-being of Pessimists.**

| **Model Summary** | | | | |
|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Change Statistics R Square Change |
| 1 | .497[a] | .247 | .231 | .247 |
| a. Predictors: (Constant), Religiosity Pessimists | | | | |

Simple Linear Regression analysis of Religiosity as showed in the above table reveals that Religiosity appeared as significant predictor of Subjective Well-being. It was found that Religiosity (Predictor) was upheld as significant predictor of Subjective Well-being (Criterion). This table shows the model summary, which indicates one predictor of the model. The correlation was found to be R= .497. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore the original covariance, the magnitude of independent variable which contributed to the dependent variable (Subjective Well-being) came out as 24.7%.

**Table 4: Represents the details of Coefficients between Religiosity and Subjective Well-being of Optimists.**

| Coefficients | | | | | | |
|---|---|---|---|---|---|---|
| Model | | Unstandardized Coefficients | | Standardized Coefficients | T | Sig. |
| | | B | Std. Error | Beta | | |
| 1 | (Constant) | -66.418 | 43.117 | | -1.540 | .130 |
| | Religiosity Pessimists | .843 | .213 | .497 | 3.967 | .000 |
| a. Dependent Variable: Subjective Well-being Pessimists | | | | | | |

The above table clearly shows that Religiosity, (the predictor variable) influenced the Subjective Well-being (Criterion). The Statistical value given in the table was found to be t = 3.967 which is significant for above mentioned predictor that is Religiosity, indicating relationship between predictor and criterion variable Subjective Well-being.

The value of Partial Correlation is r = .497, therefore predictor variable significantly influenced the degree of Subjective Well-being. The obtained finding indicates that Religiosity appeared as potential factor of Subjective Well-being among Pessimists also. It may be seen in the table that a significant positive correlation exists between Religiosity and Subjective Well-being among the Pessimists too. It means that when Religiosity increases Subjective Well-being also increases and when Religiosity decreases Subjective Well-being also decreases. Despite the fact that Pessimists have a narrow outlook on every aspect of life, there should be a negative correlation between Religiosity and Subjective well-being. This finding revealed relatively weak contribution of the independent variable towards dependent variable in the sample of Pessimists as compared to Optimists.

Several studies have confirmed that optimists tend to use coping strategies that focalize on the problem more frequently while compared with pessimists. (Scheier, et al., 1986, Rasmussen, et al., 2006, Wrosch & Scheier, 2003).

Scheier and Carver reported that optimists and pessimists have different patterns of behavior and expectations in relation to the achievement of goals. Since optimists tend to believe strongly that their actions will lead to a positive outcome, they persist in those actions and achieve their goals with more confidence often than pessimists, who usually show some fear of failure and more often withdrawn tendency, so put less efforts and disengage from the goals they have set. Scheier and Carver (1993; Scheier, Weintraub, & Carver, 1986) suggested that optimists report higher SWB because they manage critical life situations better than pessimists do.

In the light of the above studies, we may say that Pessimists are relatively not better than Optimists in any respect. Pessimists face difficulty in solving problems. They have fickle goals in their lives with the tendency of reluctance. So they often fail to cope well in face of daily

stressors, they can't adapt to Psychological illness and finally they are not better in terms of Subjective Well-being. But, if we consider the second finding of the study, a significant positive correlation between Religiosity and Subjective Well-being among Pessimists was found. One study could partially support this finding e.g. Robinson- Whelen, Kim, MacCallum and Kiecolt-Glaser (1997) reported that pessimism, but not optimism, was able to predict health and wellbeing. This finding could also be possible because an individual either Optimistic or Pessimistic may have a positive outlook in the name of religion, a pessimist may also be God-fearing and may also have a deep faith in mortality which impels him towards attending Religious activities. Therefore a Pessimist can be equal to an optimist so far the faith in Religiosity is concerned. As the Subjective Well-being of Optimists is better and Pessimists are not far behind from Optimists as observed in the study in terms of Religion, then Pessimists might show better levels of Subjective Well-being. Since the students of A.M.U served as subjects in this study and the environment of university campus is religiously conducive for offering prayer. Therefore the Well-being of Pessimists who were religious appeared to be almost similar to that of Optimists. So it is needed to conduct study in different social setting and environment. If religious practices are truly observed in any environment, might change the Pessimistic trait of the individuals as per obtained finding of the study.

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# Helplessness of Rural and Urban People

Mr. Hardik Patel[1]

**ABSTRACT:**

Present research has done to know the effect of rural and urban people on helplessness. For this total number of sample was 240 sample was selected from anand district. For the data collection Helplessness scale by G P Mathur and Raj Kumari Bhatnagar was used. Data was analysis and concluded result by 't' test. Result show, There is no significant difference between rural and urban people on helplessness.

***Keywords:*** *Helplessness, Rural and Urban People*

*Meaning of learned helplessness*

Learned helplessness is a mental state in which an organism forced to endure aversive stimuli, or stimuli that are painful or otherwise unpleasant becomes unable or unwilling to avoid subsequent encounters with these stimuli even if they are escapable, presumably because it has learned that it cannot control the view that clinical depression and related mental illnesses may result from a perceived absence of control over the outcome of a situation. Organisms that have been ineffective and less sensitive in determining the consequences of their behaviour are defined as having acquired learned helplessness.

*Learned Helplessness*

The model of learned helplessness given by Seligman(1973) describes states of helplessness that exist in humans who have experienced numerous failures ( either real or perceived ). The individual abandons any further attempts toward success. Seligman theorized that learned helplessness predisposes individuals to depression by imposing a feeling of lack of control over their life situations (McKinney & Moran, 1982). It has been empirically proven that negative expectations about the effectiveness of one's own efforts in bringing about the control over one's own environment leads to passivity and diminished initiation of responses (Abrahmson, Seligman & Teasdale, 1978). The term learned helplessness describes an organism's reaction when it is faced with important events that cannot be altered by its voluntary responses. Learned helplessness is both a behavioral state and a personality trait of one who believes that control has been lost over the reinforces in the environment. These negative expectations lead to helplessness, passivity and an inability to assert oneself.

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Learned helplessness is a psychological condition in which a human or animal has learned to believe that they are helpless. They feel that they have no control over their situation and that whatever they do is futile. As a result, they will stay passive when the situation is unpleasant, harmful or damaging. Learned helplessness undermines motivation and retards the ability to perceive success (Seligman, 1975). Martin Seligman developed the theory of depression in the mid 1960's. The theory has two main points, people become depressed when they think that they no longer have control over the reinforcements (the rewards and punishments) in their lives and that they themselves are responsible for this helpless state. Not all people become depressed as a result of being in a situation where they appear not to have control. Seligman discovered that a depressed person thought about the bad event in more pessimistic ways than a non depressed person. He called this thinking, "explanatory style".

People in a state of learned helplessness view problems as personal, pervasive, or permanent. That is, Personal they may see themselves as the problem; that is, they have internalized the problem. Pervasive they may see the problem as affecting all aspects of life. Permanent they may see the problem as unchangeable. It is a motivational problem where one might have failed in a task or two in the past which have made that individual believe that they are incapable to do anything in order to improve their performance in that task (Stipek & Freeman, 1988).

## PROBLEM OF STUDY

The problem of the present study is an under:

"**HELPLESSNESS OF RURAL AND URBAN PEOPLE**"

## OBJECTIVE OF THE STUDY

1. To study of the helplessness among rural and urban people

## HYPOTHESIS

1. There will be no difference between rural and urban people on helplessness.

## METHODOLOGY

### Sample

For this research total number of sample was 240 samples was selected from anand district. Which are 125 rural area and 115 urban area people selected.

### Tools

The following tools were used in the present study.

*1. Personal datasheet*

Certain personal information about respondents included in the sample of research is useful and important for research. Here also, for collecting such important information, personal data sheet was prepared. With the help of this personal data sheet, the information about sex, area and type of family.

*2. Helplessness scale*

The Helplessness scale developed by G P Mathur and Raj Kumari Bhatnagar was used. The scale consists 22 items in eight Areas. It was administrated on age group of 14+
In this test the Reliability coefficient has been found to be male reliability ranges 0.77-0.83 and female 0.75-.80. by test retest method and the author has reported satisfactory validity of the questionnaire.

## STATISTICAL ANALYSIS

Following statistical analysis will be used for analyzing the data
't' –test

## RESULT AND DISCUSSION

**Table: 1**
**N=240**
**Means, SDs and 't' value of Helplessness with reference to rural and urban**

| Variable | Group | N | Mean | SD | 't' | Significant level |
|---|---|---|---|---|---|---|
| Helplessness | Rural | 125 | 66.21 | 7.24 | 1.29 | NS |
| | Urban | 115 | 67.43 | 7.46 | | |

It is revealed in Table no.1 that mean score of helplessness belonging to rural and urban area people are 66.21 and 67.43 respectively. These means indicate that urban area people experienced the highest level of helplessness (67.43) as compared to the rural area people (66.21). The results indicate this as first sight. when 't' value was calculated to know statistical significant of mean difference, non-significant difference was observed between rural and urban area people. 't' value is 1.29 which is statistically non-significant. Hence the null hypothesis was accepted. Thus the results show that area has no significant effect on helplessness.

## CONCLUSION:

**1.** There is no significant difference between rural and urban area people on helplessness.

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# Mental health of Hindu and Muslim people in Ahmedabad

Meghna Gajjar[1], Dr. S. M. Kaji[2]

**ABSTRACT:**

The present study examined the effects of mental health of Hindu and Muslim people in Ahmedabad. The sample consisted of 120 people out of which 60 were Hindu and 60 were Muslim. For this purpose of investigation 'Mental Health Analysis Inventory' by A. B. Jansari, HarkantBadami, Charulata Badami was used. The data obtained were analyzed thought' test to know the mean difference between the two groups. The result shows that there is no significant difference in the mental health of Hindu and Muslim people and Hindu male-female. There is significant difference in the mental health of Muslim male and female at 0.05 Levels.

***Keywords:*** *Mental health, Hindu, Muslim, Male, Female, Ahmedabad*

Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind, body and spirit, usually meaning to be free from illness, injury or pain (as in "good health" or "healthy"). The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"(WHO1948, 2006). Although this definition has been subject to controversy, in particular as lacking operational value and because of the problems created by use of the word "complete", it remains the most enduring (Jadad2008). Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Diseases (ICD), are commonly used to define and measure the components of health.Mental health is about the ability to work and study to realize your full potential, cope with day-to-day life stresses, be involved in your community, and live your life in a free and satisfying way.A person who has good mental health has good emotional and social well-being and the capacity to cope with change and challenges. Mental health problems can affect your feelings, thoughts and actions, and cause difficulties in your everyday activities, whether at school, at work, or in relationships.

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## Mental health problems

Feeling down, tense, angry or anxious are all normal emotions, but when these feelings persist for long periods of time, or if they begin to interfere with daily life, they may become mental health problems. Most mental health problems are not very severe or long-lasting. However, it is important to get support from your friends and family, and to ask for help early, for example by visiting your local doctor (general practitioner - GP) or your local headspace Centre.

Mental illness Mental illness can occur at any age, but anxiety disorders and depression are quite common problems for young people Mental illness can affect your thoughts, feelings, actions and memory. A mental illness is usually longer-lasting than mental health problems, and causes more distress and disruption to life. There are a number of mental illnesses. In the present study, the aim of the researchers is to compare the mental health level of Hindu and Muslim people in Ahmedabad.

## OBJECTIVES

1. To study differences between Hindu and Muslim people in relation to their mental health.
2. To study differences between Hindu male and female in relation to their mental health.
3. To study differences between Muslim area male and female in relation to their mental health.

## HYPOTHESES

1. There is no significant difference between Hindu and Muslim people of mental health.
2. There is no significant difference between Hindu male and female of mental health.
3. There is no significant difference between Muslim male and female of mental healh.

## METHOD

### Sample:

The sample for the present study in Ahmedabad120 Hindu and Muslim people Selected. 60 was taken from Hindu people and 60 were taken from Muslim people.

### Tool:

To obtain data, “Mental Health Analysis Inventory” by A. B. Jansari, HarkantBadami and CharulataBadami (2011) was used for the purpose of study. The inventory consists of 100 items with yes/no response pattern. The test-retest reliability score of this test 0.92 and split half reliability score this of inventory is 0.90. Validity of this test was seen to be 0.71 which significant at 0.01 level.

## Procedure

The collection of data was spread over a period of 15 days. The researcher personally visited the selected Hindu and Muslim area in Ahmedabad. On the schedule date the researcher meet the Hindu and Muslim people and made clear to them the purpose of administration. The researcher sought their co-operation.

The instructions were explained by the researcher and the doubts were clarified. They were assured that their response will be used for research purpose only and will be kept confidential. They were suggested to give free frank and honest responses without any hesitation. The scales were administered to the people. The scales were collected only after they were responded by the subject. After the completion of the administration, the investigator conveyed her gratitude and thanks to the all subject for their kind co-operation. The raw scores were statistically analysed in terms of means; standard deviation and t-test were used to compare mental health level of the Hindu and Muslim people and relation to their Gender.

Results and Discussion

The main objective of present study was to carry out the study of mental health level among Hindu and Muslim people. In it statistical‘t’ method was used. Results discussionsof present study are as under:

Table-1 Mean, SD,SEDand‘t’ scores of mental health of Hindu and Muslim people

| Group | N | Mean | SD | SESED | ‘t’ | Sign. |
|---|---|---|---|---|---|---|
| Hindu | 60 | 67.43 | 12.37 | 1.60 | 2.14 | 0.26 NS |
| Muslim | 60 | 66.87 | 10.97 | 1.42 | | |

Non-significant. (0.05=1.98)

Table-1 depicts that the value of mean and SD of mental health of Hindu people were 67.43 and 12.37 respectively and those of Muslim people were 66.87 and 10.97respectively. The‘t’ value came out to be 0.26 which is non-significant, Thus the null hypothesis, number 1, which states “there is no significant difference between Hindu and Muslim people of mental health” was accepted. It means that the mental health ofHindu and Muslim people is of the same level.

Table-2 Mean, SD, SED and‘t’ scores of mental health of Hindu male and female

| Group | N | Mean | SD | SE | SED | ‘t’ | Sign. |
|---|---|---|---|---|---|---|---|
| Hindu-Male | 30 | 69.23 | 13.16 | 2.40 | 3.16 | 1.14 | NS |
| Hindu-Female | 30 | 65.63 | 11.24 | 2.05 | | | |

Non- Significant. (0.05=2.00)

Table-2 depicts that the value of mean and SD of mental health of Hindu male were 69.23 and 13.16 respectively and those of Hindu female were 65.63 and 11.24respectively. The‘t’ value came out to be 1.14 which is non-significant, Thus the null hypothesis, number 2, which states “there is no significant difference between Hindu male and female of mental health” was accepted. It means that the mental health ofHindu male and female is of the same level.

Table-3 Mean, SD, SED and‘t’ scores of mental health of Muslim male and female

| Group | N | Mean | SD | SE | SED | ‘t’ | Sign. |
|---|---|---|---|---|---|---|---|
| Muslim-Male | 30 | 69.87 | 12.88 | 2.35 | 2.76 | 2.17 | 0.05 |
| Muslim-Female | 30 | 63.87 | 07.93 | 1.45 | | | |

Significant at 0.05levels (2.00)

Table 3 depicts that the value of mean and SD of mental health of Muslim male were 69.87 and 12.88 respectively and those of Muslim female were 63.87 and 7.93 respectively. The‘t’ value came out to be 2.17which is significant. Thus the null hypothesis, number 3, which states “there is no significant difference between Muslim male and female of mental health” was rejected. It means there is significant difference betweenMuslim male and femaleof mental health. The conclusion is that the mental health condition of Muslim male is better of close ties, inter-personal relations, community participation, satisfaction with work and entertainment, fixed goals and viewpoint.

## CONCLUSION

Major findings of the present study are,

1. There is no significant difference between Hindu and Muslim people in Ahmedabad.
2. There is no significant difference between Hindu male and female in Ahmedabad
3. There is a significant level of difference in the mental health of Muslim male and female in Ahmedabad. The mental health level of Muslim male better than that of female.

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# Relationship between Emotional Intelligence and the Academic Achievement among College Students

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**ABSTRACT:**

Emotional Intelligence (EI) is considered as a successful predictor of academic achievement. Researchers have claimed that EI predicts success in schools/colleges/universities. The present study is an attempt in this direction. Three hundred Post-graduate girl Psychology students, studying at Indian Institute of Psychological Research, Bangalore, constituted as a sample for the present study. The students were administered with Emotional Intelligence Scale to measure their EI. EI score were compared with final semester examination marks. EI in its five domains such as Self-recognition, Self-regulation, Self-motivation, Empathy and Handling relations was positively associated with academic achievement. Over all EI score showed that 23% of the students were emotionally intelligent and excellent on academic achievement. Students, who were high on EI, were academically excellent. Results clearly indicated that there is a significant difference ($P > 0.0001$) existing between the EI and academic achievement among college students. EI played a major role in promoting academic achievement among college students. Also, the study has brought out the fact that the emotional well being could be emphasized on academic achievement

***Keywords:*** *Emotional intelligence, academic achievement, psychology students, empathy*

Emotional intelligence theory was originally developed by the research work / writings of Harvard Gardener (Harvard), Peter Solovey (Yale) John Mayer (New Hampshire) during the 1970's and 1980's. Daniel Colman's book entitled as "Emotional Intelligence" identifies 5 domains of Emotional Quotient such as Self - recognition (knowing your emotions), Self - regulation (managing your emotions), Self - motivation (motivating yourself) Empathy (recognizing and understanding others emotions) and Handling relations (managing emotions of others). (Nelson and Low, 2003; Solovey and Mayer, 1990).

Development of EI is an intentional, active and engaging process (Nelson and Low, 2003). By developing EI, one can become more productive and successful.

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EI appears to be a core ingredient that, when developed and well employed, has wide ranging benefits for learning, relationship and wellness Academic achievement and academic performance have been determined by variables such as family, school, society and motivational factors (Aremu, 2004). Dr Parthasarathy (2000), HOD, Dept. of Social Work, NIMHANS, has highlighted the role of parents and teachers in cultivating emotional intelligence (Attaches as Appendix).

Jaeger (2003) delineated the fact that EI and academic achievement are positively correlated. Abisamra (2000) reported that there is a positive relationship between academic achievement and EI. Majority of the research suggests that EI abilities lead to superior performance even in the most intellectual career. EI predicts academic achievement (Zee, et al., (2000); Parker, et a;., 2004; Marquez Martin, et al., 2006). The present study was carried out to test this assertion on final year Post – graduate Psychology girl students. .

**AIM**

Aim of the present study was to find out the relationship between EI and academic achievement among college students

**OBJECTIVE**

EI plays a major role in the academic achievement. Once it is identified at an early stage, students can be helped to develop EI so that they will be successful in the academic achievement.

The other objectives were to assess the relative effect of the measured EI with regard to five dimensions of EI such as Self-recognition, Self-regulation, Self-motivation, Empathy and Handling relationship to academic achievement, Development of EI reduces attrition rate among college students. Emotionally intelligent student can work efficiently in the workplace.

**MATERIALS AND METHOD**

Three hundred healthy and well motivated final year, M.Sc., Psychology girl students, age ranging from 23 to 25 years, studying at Indian Institute of Psychological Research, Bangalore, constituted as a sample for the present study (Table 1)..

Table 1: Sample Characteristics

| DISCIPLINE | NUMBER |
|---|---|
| M.Sc., CLINICAL PSYCHOLOGY | 100 |
| M.Sc., COUNSELLING PSYCHOLOGY | 100 |
| M.Sc., INDUSTRIAL PSYCHOLOGY | 100 |

Table 1 showed sample characteristics. Out of 300 girl students, 100 girl students each were studying Clinical Psychology, Counselling Psychology and Industrial Psychology Hence,

the sample selected for the study was a homogeneous sample. Students were administered with Emotional Intelligence Scale to measure EI. All the girl students were studying psychology as a main discipline in Post - graduation, hence, the sample selected for the study was homogenous sample.

Short details of the psychological test, is as follows:

Emotional Intelligence Scale (EIS) has been developed by Schutle et al., (1998) to measure emotional intelligence. It is a five point rating scale and the ratings are Strongly Agree, Agree, Neutral, Disagree and Strongly Disagree, which measures five domains of EI such as Self-recognition (knowing your emotions), Self-regulation (managing your emotions), Self-motivation (motivating yourself) Empathy (recognizing and understanding others emotions) and Handling relations (managing emotions of others). College students are asked to record their responses on a separate answer sheet. There are 33 items and usually it takes 20 minutes to complete the test.
Scoring: Each correct answer is awarded with marks. Minimum raw score is 33 and the maximum 165. Out of 33, seventeen items are reverse scored and they are 1, 3, 5-10, 12-13, 16-19, 24, 29, 30. All the other items are taken as it is (straight sixteen items).

| Ratings | Positive Responses | Negative Responses |
|---|---|---|
| Strongly Agree | 5 | 1 |
| Agree | 4 | 2 |
| Neutral | 3 | 3 |
| Disagree | 2 | 4 |
| Strongly Disagree | 1 | 5 |

The items are scored domain wise. The Overall score gives Emotional Quotient of the student. Higher the score, higher the Emotional Intelligence

Over all EI score was compared with final semester examination marks of the college students to find out the relationship, if any, between EI and academic achievement. The data thus collected were subjected to ANNOVA to find out the relationship, if any, between EI and academic achievement

## RESULTS AND DISCUSSION

Results of the present study were discussed in Tables 2 to 7 and Figures 1 and 2.

Table 2: Relationship between Self- recognition level and academic achievement of girl students

| SELF -RECOGNITION | | | SEMESTER MARKS OBTAINED | | F - VALUE |
|---|---|---|---|---|---|
| GRADE | NUMBER | % | MEAN | SD | |
| HIGH | 69 | 23.0 | 73.92 | 8.23 | 14.105** |
| MODERATE | 160 | 53.3 | 68.94 | 8.59 | |
| LOW | 71 | 23.7 | 60.75 | 11.54 | |

** Significant at 1% level

The mean marks obtained from Self – recognition, a dimension of EI, were compared with the academic performance. It was seen from the Table 2 that 69 girls are High (Very good), 160 are Moderate (Average) and 71 are Low (Poor) on Self-recognition dimension of EI. Similarly, girl students scored 73.92 as a mean score in the Very good category, 68.94 in the Average category and 60.75 in the Poor category on academic performance. The calculated F-Value, 14.105 was greater than the Tabular value, hence, there was a significant difference ($P < 0.01$) existing between the EI and academic achievement. The students, who were high on EI were also Very good in their academic achievement. Results of the present study were corroborated with the findings of Abisamra (2000), Zee, et al., (2000) and Aremu (2004).

Table 3: Relationship between Self- regulation level and academic achievement of girl students

| SELF –REGULATION | | | SEMESTER MARKS OBTAINED | | F - VALUE |
|---|---|---|---|---|---|
| GRADE | NUMBER | % | MEAN | SD | |
| HIGH | 65 | 21.7 | 75.04 | 7.54 | 14.274** |
| MODERATE | 149 | 49.7 | 68.22 | 9.56 | |
| LOW | 86 | 28.6 | 65.16 | 8.66 | |

** Significant at 1% level

The mean marks obtained from the academic performance were compared with the Self – regulation, a dimension of EI. Table 3 showed that 65 girls are High (Very good), 149 are Moderate (Average) and 86 are Low (Poor) on Self-regulation dimension of EI. Similarly, girl students scored 75.04 as a mean score in the Very good category, 68.22 in the Average category and 65.16 in the Poor category on academic performance. The calculated F – Value, 14.274, was greater than the tabular value, hence, there was a significant difference ($P < 0.01$) existing between the EI and academic achievement. The students, who were high on EI were also Very good in their academic achievement. Results of the present study were corroborated with the research conducted by Abisamra (2000), Zee, et al., (2000) and Aremu (2004).

Table 4: Relationship between Self- motivation level and academic achievement of girl students

| SELF –MOTIVATION | | | SEMESTER MARKS OBTAINED | | F - VALUE |
|---|---|---|---|---|---|
| GRADE | NUMBER | % | MEAN | SD | |
| HIGH | 50 | 16.7 | 72.82 | 8.35 | 5.901** |
| MODERATE | 177 | 59.0 | 69.22 | 9.35 | |
| LOW | 73 | 19.0 | 66.66 | 9.94 | |

** Significant at 1% level

The mean marks obtained from the academic performance were compared with the Self – motivation, a dimension of EI. Table 4 showed that 50 girls are High (Very good), 177 are Moderate (Average) and 73 Low (Poor) on Self-motivation dimension of EI. Similarly, girl students scored 73.82 as a mean score in the Very good category, 69.22 in the Average category and 68.66 in the Poor category on academic performance. The calculated F – Value, 5.901, was greater than the tabular value, hence, there was a significant difference ($P < 0.01$) existing between the EI and academic achievement. The students, who were high on EI were also Very good in their academic achievement. Results of the present study were corroborated with the research conducted by Abisamra (2000), Zee, et al., (2000) and Aremu (2004).

Table 5: Relationship between Empathy level and academic achievement of girl students

| EMPATHY | | | SEMESTER MARKS OBTAINED | | F - VALUE |
|---|---|---|---|---|---|
| GRADE | NUMBER | % | MEAN | SD | |
| HIGH | 27 | 9.0 | 72.66 | 9.84 | 9.753 |
| MODERATE | 154 | 51.3 | 70.06 | 9.21 | |
| LOW | 119 | 30.3 | 60.84 | 8.13 | |

** Significant at 1% level

F-Value of 9.753 calculated to determine relative effective of the Empathy – a domain of EI on achievement was significant at 1% level. Also the Table 5 indicated that score of 72.66 was scored by the students possessing high score on Empathy. The students, who were high on EI were also Very good in their academic achievement. Results of the present study were corroborated with the research conducted by Abisamra (2000), Zee, et al., (2000) and Aremu (2004).

Table 6: Relationship between Handling relations level and academic achievement of girl students

| HANDLING RE;LATIONS | | | SEMESTER MARKS OBTAINED | | F - VALUE |
|---|---|---|---|---|---|
| GRADE | NUMBER | % | MEAN | SD | |
| HIGH | 65 | 21.7 | 73.40 | 8.23 | 13.234 |
| MODERATE | 148 | 48.3 | 69.22 | 9.10 | |
| LOW | 87 | 19.8 | 64.0 | 8.57 | |

** Significant at 1% level

It was seen from the Table 6 that 65 girls are High (Very good), 148 are Moderate (Average) and 87 are Low (Poor) on Self-regulation dimension of EI. Similarly, girl students scored 75.40 as a mean score in the Very good category, 69.22 in the Average category and 64..0 in the Poor category on academic performance. There was a significant difference ($P < 0.01$) existing between the EI and academic achievement. The students, who were high on EI were also Very good in their academic achievement. Results of the present study were corroborated with the research conducted by Abisamra (2000), Zee, et al., (2000) and Aremu (2004).

Table 7: Relationship between Overall EI score and academic achievement of girl students

| OVERALL EI SCORE | | | SEMESTER MARKS OBTAINED | | F - VALUE |
|---|---|---|---|---|---|
| GRADE | NUMBER | % | MEAN | SD | |
| HIGH | 69 | 22.9 | 81.10 | 6.93 | 11.235** |
| MODERATE | 139 | 47.1 | 69.16 | 9.09 | |
| LOW | 92 | 30.0 | 65.67 | 8.65 | |

** Significant at 1% level

Table 7 showed Handling relations between EI and academic achievement. Overall 69 girls were Very good with the mean score of 81.10. The mean score was found to be decreasing gradually with reference to the EI. F-Value indicates that there was a significant difference ($P > 0.01$) existing between the EI and academic achievement. Results of the present study were corroborated with the research conducted by Abisamra (2000), Zee, et al., (2000) and Aremu (2004). An emotionally intelligent student can use such skills to overcome stress and anxiety associated with test taking situation and workplace.

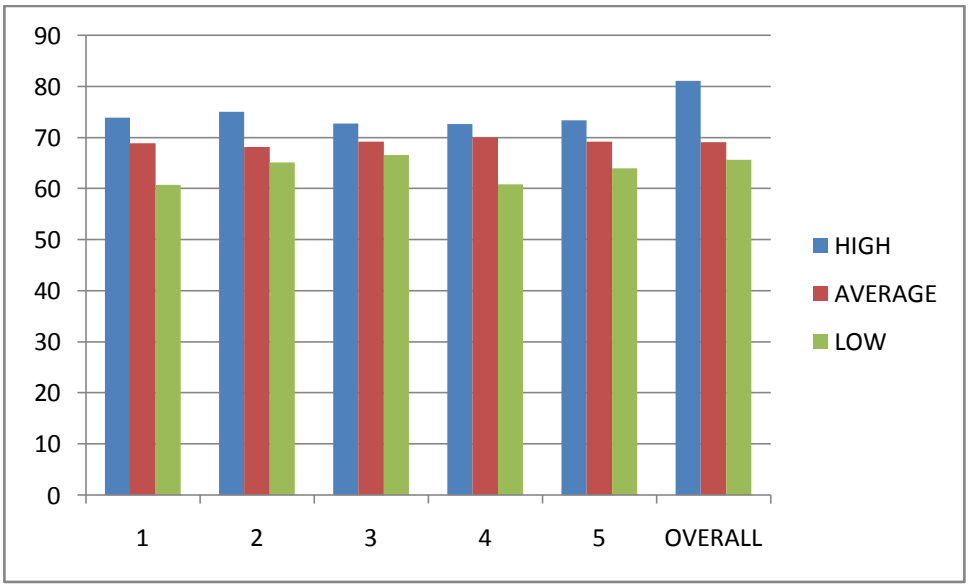


Fig 1:Level of Emotional Intelligence

1- Self-recognition, 2. Self-regulation, 3. Self-motivation, 4. Empathy and 5. Handling relations

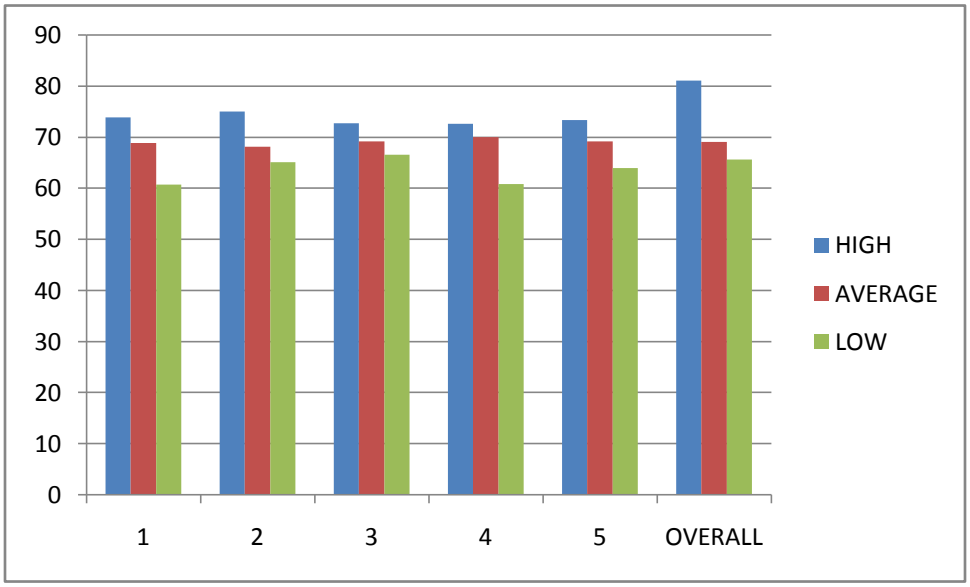


Fig 2: Academic Achievement

## SUMMARY AND CONCLUSIONS

EI appears to be a core ingredient that, when developed and well employed, has wide ranging benefits for learning, relationship and wellness. Academic achievement and academic performance have been determined by variables such as family, school, society and motivational factors. However, EI plays a major role in the Academic achievement and academic performance. Hence, the present study was undertaken to find out the relationship between EI and academic achievement among Post-graduate girl students because level of maturity will be more. Psychology students were selected because they are going to be mental health care professionals.

The following conclusions are drawn from the present study:

1. EI predicts success in academic performance of the girl students
2. EI domains such as Self-recognition, Self-regulation, Self-motivation, Empathy and Handling Relations have a strong and positive relationship on the academic achievement of the girl students
3. Higher level of EI would improve employee performance and interaction in the workplace
4. Educational psychologist should encourage the development of a strong achievement motivation in the students through counselling / intervention programmes and enabling environment
5. EI promotes not only academic achievement but also success in the family / workplace

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ANNEXURE

# Cultivating emotional intelligence in children

## ROLE OF PARENTS AND TEACHERS

**Words and actions of parents and teachers influence the child's developing self-image more than anything else in the world. Consequently, praising their accomplishments, however small, would make them feel proud; letting them do things for themselves would make them feel capable and independent. By contrast, belittling them or comparing them unfavourably to other children would make them feel worthless.**

SOME INDIVIDUALS, in spite of being gifted with high intelligence (IQ), advanced degrees, or technical expertise, are neither successful nor happy in their personal and professional lives. Such people have been intensively studied and researched by mental health experts and behavioural and social scientists. A relatively new factor called 'Emotional intelligence' is being projected by experts after their study. It refers to the capacity for recognising our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships. It describes abilities distinct from, but complementary to academic intelligence, the purely cognitive capacities measured by IQ.

In his book, 'Working with emotional intelligence', Daniel Goleman includes the following five basic emotional and social competencies:

**Self awareness:** Knowing what we are, feeling at the moment, and using those preferences to guide our decision making; having a realistic assessment of our own abilities and well grounded sense of self confidence.

**Self-regulation:** Handling our emotions so that they facilitate rather than interfere with the task at hand; being conscientious and delaying gratification to pursue goals; recovering well from emotional distress.

**Motivation:** Using our deepest preferences to move and guide us toward our goals, to help us take initiative and strive to improve, and to persevere in the face of setbacks and frustrations.

**Empathy:** Sensing what people feel, being able to take their perspective and cultivating rapport and attunement with a broad diversity of people.

**Social skills:** Handling emotions in relationships well and accurately reading social situations and networks; interacting smoothly; using these skills to persuade and lead, negotiate and settle disputes, for cooperation and team work.

These five components of emotional intelligence pave the way for actualising or utilising our potentials to the fullest extent. The experts have indicated that emotional intelligence does not mean merely 'being nice'. At strategic moments, it may demand not 'being nice', but rather, bluntly confronting someone with an uncomfortable but consequential truth they have been avoiding. Secondly, emotional intelligence does not mean giving free rein to feelings. Rather, it means managing feelings so that they are expressed appropriately and effectively, enabling people to work together smoothly toward their common goals. Finally, our level of emotional intelligence is not fixed genetically, nor does it develop only in early childhood. Unlike IQ, which changes little after our teen years, emotional intelligence seems to be largely learned, and it continues to develop as we go through life and learn from our experiences — our competence in it can keep growing.

The personal and social competencies do not develop in a vacuum. Our socialising process, especially the socialising agents — family and school, play a vital role in cultivating emotional intelligence in children. Here are some ways:

Children should get exposed to a wide range of activities apart from academic work. They should be encouraged to participate in sports and cultural activities. By getting involved in helping others in social service programmes, they come to know what life outside is. Their creativity needs to be given opportunities in fields like writing, drama, songs, dance or any kind of art. Many parents and teachers may find it a waste of time. But such activities only make one emotionally intelligent in later years.

Children start developing a sense of self as babies when they see themselves through the eyes of their near and dear ones. Their tone of voice, body language, and every expression are absorbed by children. Words and actions of parents and teachers influence the child's developing self-image more than anything else in the world. Consequently, praising their accomplishments, however small, would make them feel proud; letting them do things for themselves would make them feel capable and independent. By contrast, belittling them or comparing them unfavourably to other children would make them feel worthless. Very harsh comments bruise the inside of the child as much as blows would hurt the outside. We have to let the child know that every one makes mistakes and that parents and teachers still love them, even while correcting their mistakes.

Children want and deserve explanations as much as adults do. If we do not take time to explain, they would begin to wonder about our values and motives. Parents and teachers who reason with their children allow them to understand and learn in a nonjudgmental way.

Problems related to classroom management or family management, need to be described to children and they need to be invited to work on a solution with parents and teachers. Children who participate in decisions are more motivated to carry them out. Television shows, magazines, books and internet — children have an access to tonnes of information. Parents must be aware of what their children are watching and reading.

Parents spending time with their children would go a long way in making them feel accepted and recognised. Children who are not getting the attention they want from their parents often misbehave because they are assured of being noticed. Adolescents seem to need less undivided attention from their parents than younger children. Parents should do their best to be available when their teenager does express a desire to talk or participate in family activities.

As far as possible, whatever qualities we expect in our children, we need to possess them ourselves — respect, friendliness, honesty, and kindness. By being a good role model the children are motivated to imbibe these qualities. In other words, parents and teachers need to develop their own emotional intelligence and strengthen it in their day-to-day life so that it gets transmitted to children.

By such exposures and opportunities provided by parents and teachers, the children would be properly moulded to acquire the qualities and skills required to be emotionally intelligent to face the competitive world in the new millennium.

**Dr. R. PARTHASARATHY**

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# The Effects of Classical Music based Chakra Meditation on the Symptoms of Premenstrual Syndrome

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**ABSTRACT:**

Premenstrual syndrome (PMS) is a very common condition, occurring in women of reproductive age. This is an important source of stress for women, significantly affecting their regular functioning. Previous studies have shown that alternative forms of therapy like meditation have an effect on the symptoms associated with PMS. However, the direct link between the two has not been focused on by the larger group of researchers. In this study, the researcher intended to study the effects of classical music based chakra meditation on the symptoms of premenstrual syndrome. The sample of the study comprised of 40 college students who were screened for premenstrual syndrome based on the Shortened Premenstrual Assessment Form (SPAF) and Calendar of Premenstrual Experiences(COPE) which they were expected to fill in for one menstrual cycle. The participants who qualified for the study were allotted to the intervention group and control group. The intervention group was expected to practice a 15 minute music based chakra meditation, everyday, for one menstrual cycle, during which they also filled in the COPE. The control group was expected to fill the COPE for one menstrual cycle. Both the groups filled in the SPAF after the completion of the menstrual cycle. The results on the SPAF and COPE showed that there was significant reduction in all the post-test symptom clusters of the experimental group, compared with the pre-test symptoms. Thus, this study demonstrates that music based chakra meditation can have significant healing effects on the symptoms of premenstrual syndrome.

***Keywords:*** *premenstrual syndrome, chakra meditation, carnatic music*

Premenstrual syndrome has always been a topic closely associated with controversy, since it is a condition that affects such a large amount of people, thus inciting offended reactions when termed as a 'disorder'. When viewed as a disorder, many women who suffer from this problem have hopes of getting it treated and being relieved of the suffering (Keep & Utian, 1981).

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However, this topic has been subject to inadequate research, and in spite of the experimentation of various treatment techniques, none of the methods have proven effective enough to be standardized or established. Another cause for controversy is that the very definition has no clarity or consensus (Connolly,2001).

The symptoms of premenstrual syndrome are mainly emotional, although at times they come in a physical form. Like the name suggests, there are almost 200 symptoms that constitute this syndrome (Pfaff, 2002). The most frequent of these symptoms are bloating, weight gain, fatigue, energy loss, headaches, cramps, joint and muscle aches, low back pain, breast swelling and tenderness, cravings for sweet and/or salty food, increased or decreased sleeping hours, reduced sex drive, constipation or diarrhoea, sadness and depression, anger, irritability, aggression, anxiety, mood swings, decreased alertness, concentration trouble and withdrawal from family and friends (Pfaff, 2002).

Like previously mentioned, PMS has no established treatments (Moe,1998). Recommendations usually range from mild exercises and controlled intake of caffeine; while more severe cases demand the need for medications like antidepressants and SSRIs (Premenstrual Syndrome(PMS) -Treatment, 2013). There are, however, a few alternative forms of healing. Owing to the fact that PMS's emotional symptoms consist of mainly mood swings, the usual treatments that clinicians and therapists prescribe are relaxation techniques (Kotsirilos, Vitetta & Sali, 2011). The most widely used of these are deep breathing exercises and progressive muscle relaxation (Atreya, 2014).

In India, meditation is one of the most commonly used relaxation techniques. This technique is used to increase the mind's feelings of love and peace, powerful positive feelings that increase happiness and relaxation (Weiss, 2013). Emerging as a very effective treatment from this area is the Chakra meditation. It works on the concept that there exist three nadis(energy channels) and seven chakras( energy centres) within every human being , and all of these have to be in balance (Saradananda, 2008). Decoding and overseeing the state of all these parts is accomplished by getting to the root of this system and the link between all of these chakras. The root is the creative, called Kundalini, dormant energy that powers the full system. This spreads to each chakra through the spinal column and culminates at the top of the head (Bean,2014). Through the Chakra meditation, the person learns to pick apart and see with clarity the state of their inner system, also gaining the ability to diagnose and correct it (Bean, 2014).

It has been hypothesised that that PMS and other menstruation-related problems are born from the imbalance of energy centres – or chakras – in our body, and restoration of the balance can be done using Chakra meditation ("*Chakra System"*,n.d.).

One highly efficient form of chakra meditation is based on music and ragas (Music therapy for meditation, n.d.). Here, different chakras are associated with different ragas of carnatic music, and each is played simultaneous to the individual focussing and concentrating on each corresponding body part whose chakra is associated to the raga being played (Redmond,2004).

Each of the seven basic musical notes in the musical octave, or swaras, have a one-to-one correspondence with each of the seven chakras (Healing by Music Therapy - Ragas ,2004). Likewise, in a manner that corresponds with these swaras, certain ragas as well play a part in activating certain chakras ("Music and Chakras", n.d.)

Thus, since it is proven that classical music, by itself contains numerous properties of relaxation (Nayar,2012); and chakra meditation is also highly helpful in elimination of anxiety symptoms and mood disturbances; a combination of the two might prove to be a highly effective way of minimising the symptoms of PMS.

## METHOD

### Statement of the Problem

To identify the effect of classical music based chakra meditation on symptoms of premenstrual syndrome.

### Operational Definitions

**Premenstrual syndrome.** Premenstrual syndrome can be defined as a consistent pattern of physical and emotional symptoms that occur during the luteal phase of the menstrual cycle and cause significant interference in daily life activities.

**Music based chakra meditation.** Music based chakra meditation can be defined as the process of bringing about a balance in the different chakras of the body by focusing on the different ragas and the corresponding body parts related to each chakra.

## HYPOTHESIS

- There is no significant difference in the severity of symptoms of premenstrual syndrome of the participants in the intervention group before and after the intervention on the shortened premenstrual assessment form.
- There is no significant difference in the severity of symptoms of premenstrual syndrome of the participants in the intervention group before and after the intervention on the total score on the daily calendar
- There is no significant difference in the severity of symptoms of premenstrual syndrome of the participants in the control group between the first and second administration of the shortened premenstrual assessment form.
- There is no significant difference in the severity of symptoms of premenstrual syndrome of the participants in the intervention group before and after the intervention on the total score on the daily calendar.

### Research Design

A quantitative paradigm was used in the study. A quasi-experimental design which involves both pre-test post-test design as well as an experimental and control group was used to study the effect of the intervention on the symptoms of premenstrual syndrome.

### Sample

The sample chosen for the study was 40 female students in the age group of 18 to 23years with symptoms of premenstrual syndrome. The sample was chosen based on convenience sampling by approaching college students from different branches of study that showed a consistent pattern of premenstrual symptoms based on the Shortened Premenstrual Assessment form(SPAF) which was an online form. Initially 65 students filled in the SPAF, from which 52 students were chosen for the second stage – filling the Calendar of Premenstrual Experiences (COPE). Out of these participants, 45 were selected for the next phase and 23 were assigned to the intervention group and 22 to the control group. The final number of participants who successfully completed the study was 40.

### Tools Used

**Shortened premenstrual assessment form(SPAF).** The Shortened Premenstrual Assessment Form by Allen, McBride and Pirie (1991) was used for the basic screening of participants to see if they experienced any significant premenstrual symptoms.

**Calendar of premenstrual experiences(COPE).** After selection of participants using the SPAF, they were expected to record their daily experience of symptoms using the Calendar of Premenstrual Experiences constructed by Mortola, Girton, Beck and Yen(1991) for a period of one month.

## Procedure

Female college-going students were approached by the researcher for participation in the study through online social networks and bringing it to the notice of different colleges in Bangalore and Chennai. Female students were asked whether they experienced changes in their emotions and physical conditions in relation to their menstrual cycle. These students were given the link to the online SPAF prospective participants were identified based on the pattern of symptoms. These participants were requested to record their daily symptoms through one menstrual cycle in the COPE and mail it to the researcher after a month. This report of symptoms was analysed to identify participants who experienced consistent patterns of premenstrual symptoms, only during the luteal phase of the menstrual cycle. The participants were enrolled for the study based on their interest and availability. 45 participants were be selected and 23 participants were assigned to the intervention group and 22 to the control group respectively. Participants whose menstrual phase fell around the same time of the month were included so that the intervention can be given accordingly. Informed consent was be obtained from the participants. The intervention

consisted of the participants listening to an audio tape which consists of a 15 minute recording of music based guided chakra meditation which was formulated in consultation with an expert. The intervention group was required to do the guided meditation for three days a week for a period of one month when the researcher monitored them through Skype, and they were also be given a copy of the recording, so that they practiced the meditation at home on the other four days of the week. This was followed up through phone calls and messages. The intervention began on the first day of the menstrual cycle and ended on the first day of the next cycle. The participants recorded their symptoms everyday during this one month on the COPE and at the end of one month, they were given the SPAF. The control group was not given any intervention. However they completed the COPE and SPAF.

**Data Analysis**

Paired sample t-test was used to compare the pre-test and post-test data.

## RESULTS AND DISCUSSION

**Results**

*Table 1 showing the results of paired sample t test of pre-test and post-test score on SPAF of the intervention group*

| Variable | Administration | N | Mean | SD | t | Sig |
|---|---|---|---|---|---|---|
| Total SPAF | Pre-test | 20 | 32.25 | 6.77 | 9.28 | .000 |
| | Post test | 20 | 19.80 | 5.14 | | |

There is a significant difference between the pre-test (M=32.25, S.D.=6.77) and post-test scores (M=19.80, S.D.=5.14) on the SPAF of the intervention group; t=9.28, p = 0.000

*Table 2 showing the results of paired sample t test of pre-test and post-test total score of the intervention group on the calendar of premenstrual experiences*

| Variable | Administration | N | Mean | SD | t | Sig |
|---|---|---|---|---|---|---|
| Total | Pre-test | 20 | 151.80 | 35.25 | 9.10 | .000 |
| | Post test | 20 | 88.20 | 24.30 | | |

There is a significant difference between the pre-test (M=151.80, S.D.=35.25) and post-test scores (M=88.20, S.D.=24.30) on the total score of the intervention group. t=9.10, p = 0.000

*Table 3 showing the results of paired sample t test of first and second administration score on SPAF of the control group*

| Variable | Administration | N | Mean | SD | t | Sig |
|---|---|---|---|---|---|---|
| Total SPAF | Pre-test | 20 | 33.10 | 6.73 | .32 | .76 |
| | Post test | 20 | 31.50 | 6.78 | | |

There is no significant difference between the first month (M=33.10, S.D.=6.73) and second month scores (M=31.50, S.D.=6.78) on the SPAF of the intervention group, t=.32, p = 0.76

*Table 4 showing the results of paired sample t test of first and second month on total score of the control group on the calendar of premenstrual experiences*

| Variable | Administration | N | Mean | SD | t | Sig |
|---|---|---|---|---|---|---|
| Total | Pre-test | 20 | 129.45 | 43.07 | -4.72 | .64 |
| | Post test | 20 | 131.75 | 42.97 | | |

There is a no significant difference between the first month (M=129.45, S.D.=43.07) and second month (M=131.75, S.D.=42.97) on the total score of the intervention group, t=--4.72, p = 0.642

## DISCUSSION

The purpose of the present research was to study the effectiveness of music based chakra meditation on the symptoms of premenstrual syndrome. The results of the study indicate that Chakra meditation has had a significant effect on the intervention group, leading to a reduction in the symptoms of premenstrual syndrome. This is indicated by the analysis based on the scores on the Shortened Premenstrual Assessment Form and Calendar of Premenstrual experiences.

Table1 shows that the pre-test scores of the participants in the intervention group on the Shortened Premenstrual Assessment Form is higher than the post-test scores, indicating a reduction in the severity of symptoms after the intervention. Based on this, the hypothesis which states that there is no significant difference in the severity of symptoms of premenstrual syndrome of the participants in the intervention group before and after the intervention on the shortened premenstrual assessment form is rejected. Hence, based on these results, a conclusion can be drawn that chakra meditation has a significant effect on the reduction of symptoms of premenstrual syndrome. Meditation results in a state of mind which promotes the well-being of the individual who practices it, and results in a sense of peace. At the same time, chakra meditation is a form that involves focusing on different body parts and increasing awareness about the functioning of these organs, thereby bringing about a balance in the functioning of the entire system (Bean, 2014). These effects of meditation and regular and focused practice result in the reduction of symptoms of premenstrual syndrome which involve both physiological and

psychological symptoms. There are a few studies which may provide explanation for the research for the present study. A review study conducted by Arias, Steinberg, Banga and Trestman(2006) showed that meditation techniques have an effect on different illnesses, including premenstrual syndrome. Similarly, a study performed by Konandreas and Kolokithas (1989) showed that biofeedback and relaxation have a positive effect on mood states during the luteal phase of the menstrual cycle.

The effects of chakra meditation are also demonstrated by Table 4 which shows that the pre-test scores are higher than the post-test scores for the intervention group on the Calendar of Premenstrual Experiences. This leads to the conclusion that the intervention has led to a reduction of symptoms and has a significant effect, thus resulting in the rejection of the hypothesis which states that there is no significant difference severity of symptoms of premenstrual syndrome of the participants in the intervention group before and after the intervention on the total score on the daily calendar. These results are supported by a study conducted by Goodale, Domar and Benson(1990) on the alleviation of symptoms of premenstrual syndrome through the relaxation response. This study also used similar scales, which are the Premenstrual Assessment Form and Daily Rating Form, and it was seen that out of the three groups, the relaxation group experienced the highest benefits. Since meditation is also a kind of relaxation response, this study can offer support to the results of the present study.

An analysis was made on the specific symptoms of premenstrual syndrome based on the Calendar of Premenstrual Experiences, to check for the effect of Chakra meditation on these symptoms. The symptom clusters assessed for included Fluid retention, appetite, cognitive/autonomic and emotional symptoms. The results showed that Chakra meditation has a significant effect on the appetite related symptoms, on comparison of the pre-test and post-test scores of the intervention group and the post-test scores of the intervention and control group.

Previous studies showed that charting and recording the symptoms of premenstrual syndrome also have an effect on the reduction of symptoms. The study done by Goodale, Domar and Benson(1990) showed that there was a seventeen percent reduction of symptoms in the charting group. Hence, to rule out the effects of recording symptoms on the Calendar of Premenstrual Experiences, the present study used a control group which did not go through the intervention, but recorded their symptoms on the calendar for the entire menstrual cycle. It was hypothesized that there would be no significant difference in the severity of symptoms of premenstrual syndrome of the participants in the control group between the first and second administration of the SPAF and between the first and second month on the total score on the daily calendar. According to Table 5 and Table 8, both the hypotheses are accepted as there is no significant difference between the first and second administration on the control group, and hence shows that the recording of symptoms has not had an effect on reducing the symptoms.

Thus, an overall conclusion can be drawn from the results that the intervention group experienced a significant reduction in the premenstrual symptoms on practising a chakra meditation intervention for 15 minutes every day for a period of one month.

## CONCLUSIONS

Thus the hypotheses which stated that there is no significant difference between the pre-test and post-test scores of the intervention group on the SPAF, and the calendar of premenstrual experiences were rejected. The hypotheses which stated that there is no significant difference between the pre and post-test scores of the control group on the SPAF and the calendar of premenstrual experiences were rejected. The hypotheses which stated that there would be no difference between the intervention and control group on the post-test scores of both these tools were also rejected. Thus, it can be concluded from the results of the present study that chakra meditation has a significant effect in reducing the number and severity of symptoms of individuals with symptoms of premenstrual syndrome.

## IMPLICATIONS

The study implies that individuals, who suffer from symptoms of PMS which affect their regular functioning, can practise this form of meditation to bring them relief from the symptoms. As it requires only 15 minutes a day, it can also be practised by busy professionals. It can be used by therapists in a premenstrual clinic or a general physician as a recommendation for symptom relief. This finding opens up avenues for new research studies in this area which can focus on the effects of chakra meditation on more severe conditions associated with menstruation such as dysmenorrhoea and premenstrual dysphoric disorder. The present study studied the effects of the intervention only for a period of one month; future studies can focus on the long-term effects of practising chakra meditation on premenstrual symptoms.

## LIMITATIONS

However, there are a few limitations to the present study. The study was done only on 40 participants selected through convenience sampling, with only 20 in the intervention group. Hence, the generalization of the results to the entire population is under question. The participants were only monitored directly through Skype for only three days a week and for the rest of the four days, they were monitored through phone calls and messages, and their word was taken for the practice of the intervention. Future studies can be conducted on a larger sample and can be directly monitored every day.

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# Influence of Emotional Competence on Well-being among Adolescents

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**ABSTRACT:**

An attempt has been made to study the influence of Emotional Competence on Well-being among Male and Female Adolescents. The present study was conducted on 100 Adolescents (Male n=50 & Female n=50) using Simple Random Sampling. Emotional Competence and Well-being was assessed by using Emotional Competence Scale developed by J. S. Fulton Paiva and Dr. M. Suresh Kumar (2009) and Well-being scale developed by Jagsharanbir Singh and Dr. Asha Gupta (2001). The scale of Well-being consists of five dimensions viz ; Physical, Mental, Social, Emotional and Spiritual Well-being. After analyzing the data by Simple Linear Regression, the first finding showed the Emotional Competence appeared as a significant predictor of overall Well-being among Male Adolescents. It implies that there is a significant positive correlation between Emotional Competence and Overall Well-being among Male Adolescents. The second finding indicates that Emotional competence appeared as significant factor of Mental, Social, Emotional and Spiritual Well-being but not as factor of Physical Well-being. The third finding showed that Emotional Competence also appeared as a significant predictor overall Well-being among Female Adolescents. . It implies that there is a significant positive correlation between Emotional Competence and Overall Well-being among Female Adolescents. The last finding reveals that Emotional Competence significantly influences the degree of Physical and Emotional Well-being but doesn't influence the degree of Mental, Social and Spiritual Well-being. Well-being is a leading issue for every Individual, if Emotional Competence leads towards better Well-being among Individuals, let them express their inner feelings without any suppression.

***Keywords:*** *Emotional Competence, Well-being, Adolescents*

Adolescence is a period of transition in which a person faces challenges and difficulties that may lead him into confusion and troubles. Therefore, the Emotional Competence is critical to adolescent's development.

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It is that stage where the individual can either build up or destroy his/her career. It has been rightly said that adolescence is a period of stress and strain, storm and strike. In this competitive world, competition in every field particularly in education is very high for adolescents. Therefore, the adolescents need to have more competence to deal with the situations effectively. Adolescents should be able to cope with the stress, manage their emotions, and improve self-esteem, confidence, and decision making which leads to increase their wellbeing. Adolescents are the beneficial resources of the society. If an adolescent is competent, he/she will be able to get the job at the right place, which is beneficial for his own development and the development of the nation as a whole. However, the notion of emotional competence has acquired more attention and has been denoted as a strong predictor of success in life. Emotional competence (EC) can be understood as a group of general skills that can be applied to many types of emotion-related skills. The ability to identify and discriminate emotions is especially important in youth development and may be influenced by a person's initial orientation to his/her emotion-related problems. When an individual is less emotionally competent, he/she tries to keep away from thoughts and feelings related to the problems coming in his/her way. In such a case, he/she may fail to recognize emotions and thus be less able to resolve emotional problems in useful ways and less likely to accept his/her own feelings. Incompetent individual's wellbeing is not guaranteed whereas competent adolescents pass all the hurdles of life. Emotional competence developing through the lifespan include emotional expression and experience, understanding emotions of self and others, and emotion regulation. Children become increasingly emotionally competent over time, and growing evidence suggests that such emotional competence contributes to their concurrent social competence and well-being, as well as to later social and academic outcomes (Denham et al., 2003; Denham, Brown, & Domitrovich, 2010; Denham & Burton, 2003). Therefore, it seemed important to conduct a study in which Adolescents could be assessed in terms of their Emotional Competence and Well-being.

**Emotional competence**

Emotional competence refers to a person's ability in expressing or releasing their inner feelings (emotions). It implies an ease around others and determines our ability to effectively and successfully lead and express. Doing a thing is quite different from doing it well, where one can produce the type of effects, one desire, (White, 1959) may be termed as competence. To achieve and maintain a feeling of adequacy, the individual has to acquire a few workable assumptions about the world, Where need for competence emerges as most of the fundamental motive of life, because we survive through competence, grow through competence and actualize ourselves through competence (Allport, 1961). Boyatzis et al. offers a descriptive definition of emotional competence, 'a person demonstrates the self-awareness, self-management, social awareness and social skills at appropriate times and ways in sufficient frequency to be effective in the situation''. Emotional competence contributes to the achievement of both intrapersonal (e.g., individual well-being) and interpersonal (e.g., maintenance of important social relationships) well-being (Eisenberg et al., 2001; Shipman and Zeman, 2001). Indeed, difficulties in identifying feelings and emotions underlie depression, anxiety, delinquency, and impaired friendships (Honkalampi et al., 2009). ), emotional competence as an understanding of one's own and others' emotions and the ability to display emotions in a situation ally appropriate manner (Eisenberg et al., 1999). Individuals who lack these skills are often characterized in terms of alexithymia, which is a marked inability to identify, describe, and express one's emotions.

## Wellbeing

*"Well-being is more than just happiness as well as feeling satisfied and happy ,well-being means developing as a person, being fulfilled, and making a contribution to the community" (Shah & Mark, 2004).*

Well- being is one of the most important goals, which individuals as well as societies strive for. The term denotes that something is in a good state. It does not specify what the "something" is and what is meant by 'good'. Wellbeing can be specified in two ways: first by specifying the 'what' and secondly by spelling out the criteria of wellness (Veenhoven, 2004). So many terms such as happiness, satisfaction, hope, positive effect, well-being and quality of life have been used in the literature synonymously and interchangeably. The word 'well-being' is mostly used for specific variety of goodness, for example, living in a good environment, being of worth for the world, being able to cope with life, enjoying, etc. The concept of "wellbeing" suffers from definitional problem. In their systematic review of the definition, Pollard and Lee (2003) describe well-being as "a complex, multi-faceted construct that has continued to elude researchers' attempts to define and measure it". Wellbeing has been defined as a dynamic state characterized by reasonable amount of harmony between individual's abilities, needs, expectations, environmental demand, and opportunities (Levi, 1987). It is connotative as a harmonious satisfaction of one's desires and goals (Checola, 1975). Well-being involves subjective satisfaction and individual pleasure depending upon psychological status of the individual and his environmental conditions. Competent emotional functioning is essential for well-being. The ability to recognize, identify, and describe one's own and others' feelings are considered key aspects to emotional competence. While emotional competence includes aspects of emotion regulation (Shipman and Zeman, 2001).

## LITERATURE REVIEW

Poor emotional competence have negative implications for youths' well-being, including difficulty forming friendships and poorer academic adjustment (Eisenberg et al., 1999).

Wellbeing has been found to decrease in early to middle adolescence and reach its lowest point at age; emotional competence is generally hypothesized to be a good predictor of one's sense of subjective well-being. There is an assumption that emotionally competent individuals will have richer sense of subjective well-being. Zeidner and Olnick-Shemesh,(2010) summarized four reasons for this assumption. First, emotionally competent individuals are more aware of their emotions and more able to regulate them, which will contribute to experience higher levels of well-being. Second, the individuals with emotional competence are assumed to have richer social connections and are able to demonstrate better coping strategies. Third, with more accurate interpretation of the information yielded by the emotions and the environment, individuals with emotional competence can sustain a better sense of wellbeing. Fourth, provided that those with emotional competence would have the propensity to experience more positive affects, individuals are more prone to a richer sense of subjective well-being.

Ciarrochi and Scott,(2006) carried out a longitudinal study to investigate causal relations and the link between emotional competence and well-being. They found that people with effective

problem orientation were less likely to experience depression, anxiety, and stress and were more likely to experience positive moods. Catalano et al. state that the enhancement of competence can help prevent other negative outcomes and is indicative of positive youth development.

Individuals with high EC are able to identify their emotions as well as those of others, express them in a socially acceptable manner, understand their causes and consequences, regulate them when they are not appropriate to the context or to their goals, and use them to enhance thoughts and actions (Mayer & Salovey, 1997). While those individuals are able to take advantage of emotions without letting the latter lead them astray, individuals with low EC have a hard time taking into account the information emotions convey and are commonly overwhelmed by them (Mikolajczak, Quoidbach, Kotsou, & Nelis, 2009 )
Nelis, et al.(2011) and Kotsou, et al.(2011) showed that improving the level of EC through a brief psychological intervention led to increased well-being, decreased cortisol and somatic complaints, enhanced social relationships and greater employability.

## OBJECTIVES

1. To see the influence of Emotional Competence on Overall Well-being among Male adolescents.
2. To examine the influence of Emotional Competence on different dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) among Male adolescents.
3. To see the influence the influence of Emotional Competence on Overall Well-being among Female adolescents.
4. To examine the influence of Emotional Competence on different dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) among Female adolescents.

## RESEARCH QUESTIONS

Taking into consideration the objectives of the study, the following Research questions were formulated.

1. Is there any influence of Emotional Competence on Overall Well-being among Male adolescents?
2. Is there any influence of Emotional Competence on different dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) among Male adolescents?
3. Is there any influence the influence of Emotional Competence on Overall Well-being among Female adolescents?
4. Is there any influence of Emotional Competence on different dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) among Female adolescents?

## METHODOLOGY

### Tools Used

*Emotional Competence Scale*

Emotional competence scale developed by J. S. Fulton Paiva and Dr. M. Suresh Kumar (2009) w as used to assess the Emotional Competence scores of participants. It can be administered to all t he age groups. It contains 35 items ranging from always to never. 35 minutes is the average time to complete. . The items in the scale provide the adequate content valid. Reliability co-efficient of correlation between forms is 0.712, equal-length Spearman-Brown is 0.721, Guttman Split-hal f is 0.719 and unequal-length Spearman-Brown is 0.719.

*Well-being Scale*

Wellbeing scale by Jagsharanbir Singh and Dr.Asha Gupta, (2001) consists of 50 items ranging from very much to not so much. It contains five dimensions such as physical wellbeing, mental wellbeing, emotional wellbeing, spiritual wellbeing. Each dimension contains 10 items. This scale has an excellent Test-retest reliability (0.98) and Spilit half reliability(0.96).Content and Concurrent validity was established. Concurrent validity of the scale was determined by comparing it the scores of Subjective Well-being Inventory by Sall and Nagpal (1992). Correlation between Subjective Well-being inventory and different dimensions of this scale were -0.45, 0.78, -0.90, 0.28 and 0.18 respectively. The total correlation was found to be 0.53

### Sample

The students of Aligarh Muslim University served as sample in this study. Simple random sampling was used to select the participants. The total no. of participants consisted of 100 adolescents, with equal number of Male (n=50) and Female (n=50).

### Procedure

The data of the present study was collected through personal contact with the participants individually or in small groups. Before administering the tools, the purpose of the study was explained to the participants and they were assured that their responses would be kept confidential and will be used for research purpose. After establishing the rapport with the participants, they were requested to fill the emotional competence scale and the scale of wellbeing. Emotional competence scale took 35 mints where as wellbeing scale took 40 mints to complete. In this way, the data was collected from the participants. The obtained data was analyzed by the means of simple linear regression.

## RESULTS

Table 1: Represents Linear Regression Analysis to find out relationship between Emotional Competence and Well-being of Male Adolescents.

| Model Summary | | | | |
|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Change Statistics R Square Change |
| 1 | .899 | .808 | .804 | .808 |
| a. Predictors: (Constant), Emotional Competence Male | | | | |

The above table shows Simple Linear Regression analysis of Emotional Competence, it showed that Emotional Competence appeared as significant predictor of Well-being. It was found that Emotional Competence (Predictor) was upheld as significant predictor of Well-being (Criterion). This table shows the model summary, which indicates one predictor of the model. The correlation was found to be R=.899. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore, the original covariance, the magnitude of independent variable, which contributed to the dependent variable (Well-being), came out as 80.8%.

Table 2: Represents the details of Coefficients between Emotional Competence and Well-being of Male Adolescents.

| Coefficients | | | | | | |
|---|---|---|---|---|---|---|
| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. |
| | | B | Std. Error | Beta | | |
| 1 | (Constant) | 181.190 | 2.991 | | 60.579 | .000 |
| | Emotional Competence Male | .342 | .024 | .899 | 14.233 | .000 |
| a. Dependent Variable: Well-being Male overall | | | | | | |

The above table clearly shows that Emotional Competence (the predictor variable) influenced Well-being (Criterion). The Statistical value given in the table was found to be t = 14.233 which is significant for above-mentioned predictor that is Emotional Competence indicating a relationship between predictor and criterion variable Well-being.

The value of Partial Correlation is r = .899, therefore predictor significantly influenced the degree of Well-being. This finding indicates that Emotional Competence appeared as factor of Well-being among Male adolescents. The table indicates a significant positive correlation

between Emotional Competence and Well-being among Male adolescents. It means that when Emotional Competence increases, Well-being also increases and when Emotional Competence decreases Well-being decreases.

Table 3: Represents Linear Regression Analysis to find out relationship between Emotional Competence and Different dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) of Male Adolescents.

| Model Summary | | | | |
|---|---|---|---|---|
| **Model** | **R** | **R Square** | **Adjusted R Square** | **Change Statistics R Square Change** |
| Physical Well-being Male | .035 | .001 | -.020 | .001 |
| Mental Well-being Male | .927 | .859 | .856 | .859 |
| Social Well-being Male | .689 | .474 | .463 | .474 |
| Emotional Well-being Male | .725 | .526 | .516 | .526 |
| Spiritual Well-being Male | .344 | .118 | .100 | .118 |
| a. Predictors: (Constant), Emotional Competence Male | | | | |

The above table shows Simple Linear Regression analysis of Emotional Competence, it showed that Emotional Competence appeared as insignificant predictor of Physical Well-being but significant predictor of Mental, Social, Emotional and Spiritual Well-being among Male adolescents. This table shows the model summary, which indicates one predictor of the model. The correlation on different dimensions of Well-being was found to be R=.035, .927, .689, .725 and .344 respectively. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore, the original covariance, the magnitude of independent variable, which contributed to the dependent variable (Different Dimensions of Well-being), came out as 00.1%, 85.9%, 47.4%, 52.6% and 11.8% respectively.

Table 4: Represents the details of Coefficients between Emotional Competence and Different Dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) of Male Adolescents.

| Coefficients | | | | | |
|---|---|---|---|---|---|
| | Unstandardized Coefficients | | Standardized Coefficients | | |
| **Model** | **B** | **Std. Error** | **Beta** | **t** | **Sig.** |
| Constant | 42.603 | 6.909 | | 6.167 | .000 |
| Emotional Competence Male | .013 | .055 | .035 | .243 | .809 |
| Constant | 5.257 | 2.313 | | 2.273 | .028 |
| Emotional Competence Male | .317 | .019 | .927 | 17.079 | .000 |
| Constant | 34.905 | 1.495 | | 23.340 | .000 |
| Emotional Competence Male | .079 | .012 | .689 | 6.580 | .000 |
| Constant | 61.358 | 2.243 | | 27.352 | .000 |
| Emotional Competence Male | -.131 | .018 | -.725 | -7.295 | .000 |
| Constant | 37.067 | 3.121 | | 11.877 | .000 |
| Emotional Competence Male | .064 | .025 | .344 | 2.537 | .014 |
| **Dependent Variable:** Male (Physical Well-being, Mental Well-being, Social Well-being, Emotional Well-being and Spiritual Well-being) | | | | | |

The above table clearly shows that Emotional Competence (the predictor variable) influenced Mental, Social, Emotional and Spiritual Well-being (Criterion) but does not influence Physical Well-being (Criterion). The Statistical values given in the table were found to be t = 17.079, 6.580, -7.295, 2.537 and .243 respectively.

These t-values are significant for above-mentioned predictor that is Emotional Competence indicating a relationship between predictor and criterion variables (Mental, Social, Emotional and Spiritual) Well-being and indicating an insignificant relationship between predictor and criterion variable (Physical Well-being).

The values of Partial Correlation is r = .035, .927, .689, -.725 and .344. Therefore, predictor significantly influenced the degree of Mental, Social, Emotional and Spiritual Well-being, but does not influence the degree of Physical Well-being. These findings indicate that Emotional Competence appeared as factor of different dimensions of Well-being except Physical Well-being among Male adolescents. The table indicates a significant positive correlation exists between Emotional Competence and Mental, Social, and Spiritual Well-being, a significant negative correlation between Emotional Competence and Emotional Well-being and indicates an insignificant positive Correlation between Emotional Competence and Physical Well-being.

Table 5: Represents Linear Regression Analysis to find out relationship between Emotional Competence and Well-being of Female Adolescents.

| Model Summary | | | | |
|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Change Statistics R Square Change |
| 1 | .397 | .158 | .140 | .158 |
| a. Predictors: (Constant), Emotional Competence Female | | | | |

The above table shows Simple Linear Regression analysis of Emotional Competence, it showed that Emotional Competence appeared as significant predictor of Well-being. It was found that Emotional Competence (Predictor) was upheld as significant predictor of Well-being (Criterion). This table shows the model summary, which indicates one predictor of the model. The correlation was found to be R=.397. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore, the original covariance, the magnitude of independent variable, which contributed to the dependent variable (Well-being), came out as 15.8%.

Table 6: Represents the details of Coefficients between Emotional Competence and Well-being of Female Adolescents.

| Coefficients | | | | | | |
|---|---|---|---|---|---|---|
| Model | | Unstandardized Coefficients | | Standardized Coefficients | T | Sig. |
| | | B | Std. Error | Beta | | |
| 1 | (Constant) | 175.248 | 11.942 | | 14.675 | .000 |
| | Emotional Competence Female | .324 | .108 | .397 | 2.996 | .004 |
| a. Dependent Variable: Well-being overall Female | | | | | | |

The above table clearly shows that Emotional Competence (the predictor variable) influenced Well-being (Criterion). The Statistical value given in the table was found to be t = 2.99 which is significant for above-mentioned predictor that is Emotional Competence indicating a relationship between predictor and criterion variable Well-being.

The value of Partial Correlation is r = .397, therefore predictor significantly influenced the degree of Well-being; this finding indicates that Emotional Competence appeared as factor of Well-being among Female adolescents. The table indicates a significant positive correlation exists between Emotional Competence and Well-being among Female adolescents. It means that when Emotional Competence increases, Well-being also increases and when Emotional Competence decreases Well-being also decreases.

Table 7: Represents Linear Regression Analysis to find out relationship between Emotional Competence and Different dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) of Female Adolescents.

| Model Summary | | | | |
|---|---|---|---|---|
| **Model** | **R** | **R Square** | **Adjusted R Square** | **Change Statistics R Square Change** |
| Physical Well-being Female | .529 | .280 | .265 | .280 |
| Mental Well-being Female | .075 | .006 | -.015 | .006 |
| Social Well-being Female | .080 | .006 | -.014 | .006 |
| Emotional Well-being Female | .333 | .111 | .092 | .111 |
| Spiritual Well-being Female | .114 | .013 | -.008 | .013 |
| a. Predictors: (Constant), Emotional Competence Female | | | | |

The above table shows Simple Linear Regression analysis of Emotional Competence, it showed that Emotional Competence Appeared as significant predictor of Physical and Emotional Well-being but insignificant predictor of Mental, Social, and Spiritual Well-being among Female adolescents. This table shows the model summary, which indicates one predictor of the model. The correlation on different dimensions of Well-being was found to be R=.529, .075, .080, .333 and .114 respectively. R Square change mentioned in the above table indicates the actual contribution of predictor variable to the criterion variable. Therefore the original covariance, the magnitude of independent variable which contributed to the dependent variable (Different Dimensions of Well-being) came out as 28.0%, 00.6%, 00.6%, 11.1% and 01.3% respectively.

Table 8: Represents the details of Coefficients between Emotional Competence and Different Dimensions of Well-being (Physical, Mental, Social, Emotional and Spiritual) of Female Adolescents.

| **Coefficients** | | | | | |
|---|---|---|---|---|---|
| | **Unstandardized Coefficients** | | **Standardized Coefficients** | | |
| **Model** | **B** | **Std. Error** | **Beta** | **t** | **Sig.** |
| Constant | 18.456 | 5.409 | | 3.412 | .001 |
| Emotional Competence Female | .212 | .049 | .529 | 4.320 | .000 |
| Constant | 45.027 | 8.935 | | 5.039 | .000 |
| Emotional Competence Female | -.042 | .081 | -.075 | -.518 | .607 |
| Constant | 39.615 | 6.792 | | 5.832 | .000 |
| Emotional Competence Female | .034 | .062 | .080 | .558 | .580 |
| Constant | 22.252 | 7.925 | | 2.808 | .007 |
| Emotional Competence Female | .176 | .072 | .333 | 2.444 | .018 |
| Constant | 49.899 | 7.694 | | 6.485 | .000 |
| Emotional Competence Female | -.055 | .070 | -.114 | -.793 | .431 |
| **Dependent Variable:** Female (Physical Well-being, Mental Well-being, Social Well-being, Emotional Well-being and Spiritual Well-being) | | | | | |

The above table clearly shows that Emotional Competence (the predictor variable) influenced Physical and Emotional Well-being (Criterion) but does not influence Mental, Social and

Spiritual Well-being (Criterion). The Statistical values given in the table were found to be t = 4.320, 2.444, -.518, .558 and -.793 respectively.

These t-values are significant for above mentioned predictor that is Emotional Competence indicating a relationship between predictor and criterion variable (Physical and Emotional) Well-being and also indicating an insignificant relationship between predictor and criterion variable (Mental, Social and Spiritual Well-being).

The values of Partial Correlation is r = .529, -.075, .080, .333 and -.114. Therefore, predictor significantly influenced the degree of Physical and Emotional Well-being, but does not influence the degree of Mental, Social and Spiritual Well-being. These findings indicate that Emotional Competence appeared as factor of Physical and Emotional Well-being. The table indicates a significant positive correlation exists between Emotional Competence and Physical and Emotional Well-being, an insignificant positive correlation between Emotional Competence and Social Well-being and also indicates an insignificant negative Correlation between Emotional Competence and Mental and Spiritual Well-being.

## DISCUSSION

The present study was aimed to see the influence of Emotional competence on Well-being among male and female adolescents. The findings revealed that Emotional Competence appeared as a significant predictor of Well-being among both male and female adolescents. These findings are consistent with the findings of Zeidner and Olnick-Shemesh (2010), who found that emotionally competent individuals are more aware of their emotions and more able to regulate them, which will contribute to experience higher levels of well-being. Second, the individuals with emotional competence are assumed to have richer social connections and are able to demonstrate better coping strategies. Third, with more accurate interpretation of the information yielded by the emotions and the environment, individuals with emotional competence can sustain a better sense of well-being.

After determining the influence of Emotional competence on different dimensions of well-being among male and female adolescents. The findings revealed that Emotional Competence appeared as significant predictor of Mental, Social and Spiritual well-being among male adolescents, a significant positive correlation was also found between Emotional competence and Physical well-being and Emotional well-being among female adolescents. The overall well-being is consisted of Five dimensions that is Physical, Mental, Social, Emotional and Spiritual Well-being. These findings could be supported by the study conducted by Nelis et al. (2011) and Kotsou et al. (2011) they showed that improving the level of EC through a brief psychological intervention led to increased well-being, decreased cortisol and somatic complaints, enhanced social relationships and greater employability. Catalano et al, (2004) state that the enhancement of competence can help prevent other negative outcomes and is indicative of positive youth development.

Insiginificant correlations were found between Emotional competence and Physical Well-being among male adolescents. It means that if EC increases it neither influences nor deteriorates the physical well-being of male adolescents. The reason could be that the males are more curious about their physical built. Therefore they engage themselves in different types of physical exercises. As a result, their well-being remains intact. It hardly matters if male adolescents are emotionally competent or incompetent, they take care of their physical health in a best possible manner.

Insignificant correlations were also found between emotional Competence and Mental, Social and Spiritual Well-being among female adolescents. In the present scenario, females face stressful and anxiety provoking situations but with a mindset of competition with others they try to cope with these situations. Females also engage themselves in social gatherings and have friends more than the males. Females are more diverted towards their religion, they cannot discriminate in the name of religion. So far as the sample was taken from A.M.U. The religious environment might also be a factor for predicting their spiritual well-being. In the light of the above points, we can say that the Mental, Social and Spiritual well-being of Females remained intact whether they were emotionally competent or emotionally incompetent.

## CONCLUSION

Emotional competence can have positive implications for adolescents' Well-being including better adjustment, good academic achievement, forming friendship, participate social gatherings etc. Emotionally competent adolescents can be able to cope with the stress and can sustain better sense of wellbeing, develop the confidence for attaining their goals.

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# Mental Health of Employed and Unemployed People in Ahmedabad

Jain Ashika[1], Dr. S. M. Kaji[2]

**ABSTRACT:**

The present study examined the effects of mental health of employed and unemployed people in Ahmedabad. The sample consisted of 120 people out of which 60 were employed people and 60 were unemployed people. For this purpose of investigation 'Mental Health Analysis Inventory' by A. B. Jansari, Harkant Badami, Charulata Badami was used. The data obtained were analyzed through't' test to know the mean difference between the two groups. The result shows that there is no significant difference in mental health of employed and unemployed people and employed male and female in Ahmedabad. There is significant difference in mental health of unemployed male and female people at 0.05 Levels.

***Keywords:*** *Mental health, Employed, Unemployed, Male, Female, Ahmedabad*

Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind, body and spirit, usually meaning to be free from illness, injury or pain (as in "good health" or "healthy"). The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"(WHO1948, 2006). Although this definition has been subject to controversy, in particular as lacking operational value and because of the problems created by use of the word "complete", it remains the most enduring

(Jadad2008). Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Diseases (ICD), are commonly used to define and measure the components of health. Mental health is about the ability to work and study to realize your full potential, cope with day-to-day life stresses, be involved in your community, and live your life in a free and satisfying way. A person who has good mental health has good emotional and social well-being and the capacity to cope with change and challenges. Mental health problems can affect your feelings, thoughts and actions, and cause difficulties in your everyday activities, whether at school, at work, or in relationships.

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**Mental health problems:**

Feeling down, tense, angry or anxious are all normal emotions, but when these feelings persist for long periods of time, or if they begin to interfere with daily life, they may become mental health problems. Most mental health problems are not very severe or long-lasting. However, it is important to get support from your friends and family, and to ask for help early, for example by visiting your local doctor (general practitioner - GP) or your local headspace Centre.
Mental illness Mental illness can occur at any age, but anxiety disorders and depression are quite common problems for young people Mental illness can affect your thoughts, feelings, actions and memory. A mental illness is usually longer-lasting than mental health problems, and causes more distress and disruption to life. There are a number of mental illnesses.In the present study, the aim of the researchers is to compare the mental health level of employed and unemployed people in ahmedabad.

**OBJECTIVES**

1. To study differences between employed and unemployed people in relation to their mental health.
2. To study differences between employed male and female in relation to their mental health.
3. To study differences between unemployed male and female in relation to their mental health.

**HYPOTHESES**

1. There is no significant difference between employed and unemployed people of mental health.
2. There is no significant difference between employed male and female of mental health.
3. There is no significant difference between unemployed male and female of mental health.

**METHOD**

**Sample:**

The sample for the present study in Ahmedabad120 employed and unemployed people was

Selected.60 were taken from employed people and 60 were taken from unemployed people.

**Tool:**

To obtain data, “Mental Health Analysis Inventory” by A. B. Jansari, HarkantBadami and CharulataBadami (2011)was used for the purpose of study. The inventory consists of 100 items with yes/no response pattern. The test-retest reliability score of this test 0.92 and split half

reliability score this of inventory is 0.90. Validity of this test was seen to be 0.71 which significant at 0.01 level.

**Procedure**

The collection of data was spread over a period of 20 days. The researcher personally visited the selected employed and unemployed in Ahmedabad. On the schedule date the researcher meet the employed and unemployed people and made clear to them the purpose of administration. The researcher sought their co-operation.

The instructions were explained by the researcher and the doubts were clarified. They were assured that their response will be used for research purpose only and will be kept confidential. They were suggested to give free frank and honest responses without any hesitation. The scales were administered to the people. The scales were collected only after they were responded by the subject. After the completion of the administration, the investigator conveyed her gratitude and thanks to the all subject for their kind co-operation. The raw scores were statistically analysed in terms of means; standard deviation and t-test were used to compare mental health level of the employed and unemployed people and relation to their Gender.

RESULTS AND DISCUSSION

The main objective of present study was to carry out the study of mental health level among employed and unemployed people. In it statistical‘t’ method was used. Results discussion of present study is as under:

Table-1 Mean, SD, SED and‘t’ scores of mental health of employed and unemployed people

| Group | N | Mean | SD | SE | SED | ‘t’ | Sign. |
|---|---|---|---|---|---|---|---|
| Employed | 60 | 64.82 | 11.84 | 1.54 | 3.36 | 0.68 | NS |
| Unemployed | 60 | 62.55 | 23.24 | 2.99 | | | |

Non-significant. (0.05=1.98)

Table-1 depicts that the value of mean and SD of mental health of employed were 64.82 and 11.84 respectively and those of unemployed were 62.55 and 23.24respectively. The‘t’ value came out to be 0.68 which is non-significant, Thus the null hypothesis, number 1, which states “there is no significant difference between employed and unemployed of mental health” was accepted. It means that the mental health ofemployed and unemployed people is of the same level.

Table-2 Mean, SD, SED and‘t’ scores of mental health of employed male and female

| Group | N | Mean | SD | SE | SED | ‘t’ | Sign. |
|---|---|---|---|---|---|---|---|
| Employed-Male | 30 | 65.23 | 11.24 | 2.05 | 3.04 | 0.27 | NS |
| Employed-Female | 30 | 64.40 | 12.34 | 2.25 | | | |

Non-Significant.(0.05=1.98)

Table-2 depicts that the value of mean and SD of mental health of employed male were 65.23 and 11.24 respectively and those of employed female were 64.40 and 12.34respectively. The‘t’ value came out to be 0.27 which is non-significant, Thus the null hypothesis, number 2, which states “there is no significant difference between employed male and female of mental health” was accepted. It means that the mental health ofemployed male and female is of the same level.

Table-3 Mean, SD, SED and‘t’ scores of mental health of unemployed male and female

| Group | N | Mean | SD | SE | SED | ‘t’ | Sign. |
|---|---|---|---|---|---|---|---|
| Employed-Male | 30 | 64.47 | 13.15 | 1.71 | 2.95 | 1.41 | NS |
| Employed-Female | 30 | 64.63 | 09.35 | 2.40 | | | |

Non- Significant.

Table-3 depicts that the value of mean and SD of mental health of unemployed male were 64.47 and 13.15 respectively and those of unemployed female were 64.63 and 09.35respectively. The‘t’ value came out to be 1.41 which is non-significant, Thus the null hypothesis, number 3, which states “there is no significant difference between unemployed male and female of mental health” was accepted. It means that the mental health ofunemployed male and female is of the same level.

## CONCLUSION

Major findings of the present study are,

1. There is no significant difference between employed and unemployed people in Ahmedabad.
2. There is no significant difference between employed male and female in Ahmedabad.
3. There is no significant difference between unemployed male and female in Ahmedabad.

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# Psychological State of Working and Non-Working Woman's Child

Chaitali R. Tailor[1]

***Keywords:*** *Mental health, Employed, Unemployed, Male, Female, Ahmedabad*

Environmental factors play a vital role in the growth and development of a child. The contribution of Manu Smriti Granth towards Indian culture holds the importance, that believes man and woman to be two important pillars of society and owes the responsibility being parents. It is saying in Gujarati that,

એક આચાર્ય દશ ઉપાધ્યાઓ કરતાં શ્રેષ્ટ છે.
એક પિતા સો આચાર્યો કરતાં શ્રેષ્ટ છે.
પરંતુ એક માતા હજાર પિતાઓ કરતાં શ્રેષ્ઠત્તમ છે.

This says that parent has a superior role to play than to a teacher in child's development. To stand with the time, women are now becoming career oriented. Cultural nourishment is now an alarming concern as both man and woman remains occupied with job/business.

According to **Vandana Desai (1978),** due to socio-political make up of our country, every educated or uneducated girl is necessitated to earn. The total count of working women in India in all sectors is more than **10 cores**. Apparently, both parent being working are likely to devote less of time in the upbringing of their child which affects the mental and personality development of a child which disturbs the mental health of a child.

**Singh (1996)** in his study says that a child of a working women tends to be free, open minded, self reliant, independent, brave, flexible and easy to gel up kind.

**Rana & Carr (1998)** studies say that compared to boys, daughter of a working mothers see their parents as less hostile, less authoritarian and more loving.

**Bandura and Walter (1963)** says that kid who is deprived of their parent's love and attention are more aggressive and rebellious in nature.

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At last, the responsibility of shaping the future of an adolescent lies to parents. When varied situation gets messed up and affect each other, the concern is to see what outcomes these situation bears. Again, in near future when every woman would be working, how will she ensure that their child is not depressed? How a working women will see for the mental well being and overall personality of their child? These questions needs immediate answer in recent times.

**Working Women means -**

Working Women are the ones who earns salary/wages outside the home alongwith the care taking of their child and the household chores.

**-William Bauer – 2006**

Also, "Women working in Government, Semi-Government or Private sector and drawing salary on lump sum or daily basis."

**-Aitin Saadat – 2009**

**Non-Working Women means -**

"Women who does all housework and shoulders all the social responsibilities without any expectation of monetary returns."

A study done by **Navbharat Times in 1963** states that, working women falls the expectation in getting sympathy and support from their family.

This proves that inspite playing various roles in the family, women are subjected to psychological questions.

A study on the effects of the Mother's employment on child includes research works of **Jonas & Bride (1980), Rob & Raven (1982), Baal (1988), Vijaylaxmi (1989), Singh(1991) Singh (1996), Joshi & Juyal (1997), Gulati (1998),**

All these studies are made in relation to the impact of mother's employment on conditions of the family, the upbringing of an adolescent and its behavioral development.

**ADOLESCENCE MEANS**

A psychologist named, **A.T. Jersild** has stated that, "Adolescent is that phase of life, in which young girls and boys mentally, aggressively, physically and socially takes transit from late childhood to early adulthood.

## Problems of the Adolescence

Any kind of change brings with it the associated problems. Adolescence is the age of transit from late childhood to early adulthood. **Crow & Crow** named psychologist has listed the problems of adolescent as below –

1. Family relations of the teenager and problems arising out of that.
2. Problems arising out of the inner conflicts faced by them.
3. Problems regarding consciousness of the outward physical appearance.
4. Problems related to intellect and aptitude.
5. Problems in selection of Career and Business.
6. Problems adjusting with the opposite gender.

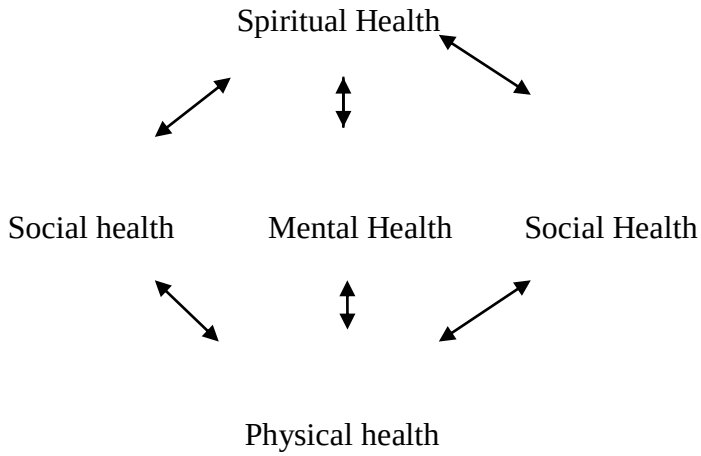
## MENTAL HEALTH MEANS

The question of mental well-being is the most burning question of the modern times. If a person really wants to be happy and successful, he will have to learn the art of staying healthy. A mentally healthy person is able to know and understand his own self. He is able to differentiate between the right and the wrong before starting to do anything and forecast the future results. He stays confident and constantly feels that he holds a position in the world. Many sees themselves as a weak, and take blames for all the failures in all the tasks. They keeps on checking the work after completion, for example-

-Checking on with the count of money repeatedly,
-Frequent checks with the wallet or money in the pocket,
-Locks the room, but more than double-checks the lock by pulling on it.

Such acts prove that such persons lack confidence in their own self and their work done. Weakness, Inferiority complex, unnecessary tensions or scares, etc. show the ill-being of the mental health.

Well, the world of psychological health is quite vast. It can be that the whole world goes round the health. Mental health is at the center of the overall health square. It holds the foremost position. The four pillars of health are also dependent on it. Its figure can be as displayed below –




Everyone has to pass through three stages, (1) Ignorance (2) Opposition (3) Acceptance. The person, who is able to foresee a long way ahead of its present, surely becomes a prey to misunderstandings. Meaning by, let opposition and suppression come by. These hindrances will be crossed over if we stand confident and unmoved. This proves that necessity shapes the one's being. Has it ever happened that, you were deprived of something that you really needed? Or you have not got it?

**Active Trusts in the field of Mental Health**

In America's many of the top rated schools have the syllabus of CATCHPHRASE - which says that with early treatment, many mental sicknesses can be ceased. Other than this, these are other trusts in America working for the psychological state.

1. National Institute of Mental Health.
2. National School of Mental Health.
3. National Committee for anti mental illness
4. B.M. Institute of Mental health
5. Yog and Self-development Academy
6. Mental Health Education and Research Trust.

**Symptoms of mentally healthy persons**

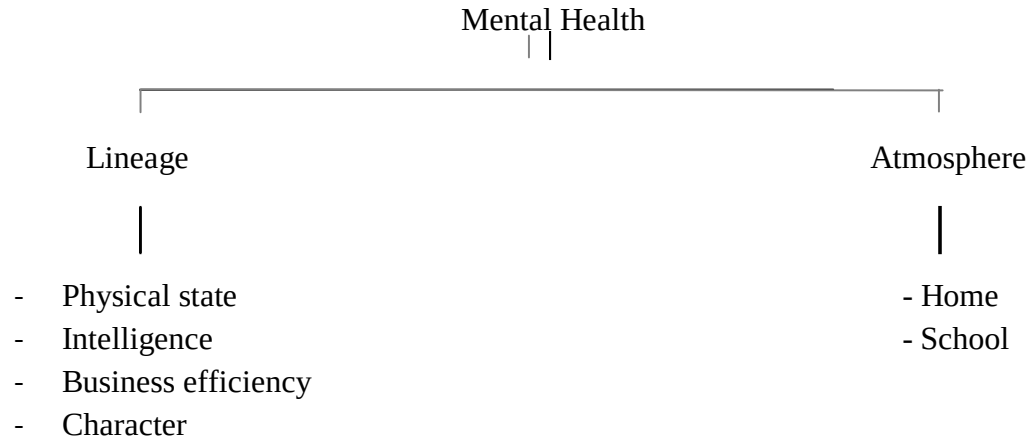
**Dr. A. M. Patel and others (2003)** voted for the following symptoms seen in the mentally healthy persons –

1. Physical Health
2. Tolerance
3. Determination
4. Responsibility
5. Socialite

6. Punctuality
7. Self-esteem
8. Self-confidence
9. Trust on others
10. Adaptability
11. Strong character
12. Love for independence
13. Non-reliance on Self defence.
14. Emotional Quotient
15. Vision of life

**Factors affecting the mental health**

As per views of **Dr. M. Panchal (1977)**, the mental health is affected by two broad factors –




**Matters endangering Mental Well-being**

To stay healthy mentally means to "stay happy". Psychological health and happiness are deep-routed. Happiness is an encouraging sparkle. Until people do the things that make them happy, mental well-being is not in danger. But when there is conflict, mental health will be at stake. Factors that put mental health in danger are as follows –

1. Stress
2. Suppression
3. Aggressiveness
4. Lake of physical health
5. Deficiency of the social quotient
6. Instinctual Drive
7. Dissatisfaction of needs

8. Depression & Struggle
9. Lack of proper development in childhood
10. Slow language development, autism, financial conditions, etc.

**Ways to maintain mental Health**

1. For speedy development of an adolescent, they should be made aware of the changes occurring in their body. This will help cope up with the changing scenario and saves them from disappointment.
2. Inherent energy in an adolescent to be evolved and accepted to best fit the socially accepted way of life.
3. Make them know the real world which will release the tension and stress.
4. At this stage proper diet nourishment is necessary. They should be motivated to stay active by doing exercise and enrolling in outdoor activities.
5. Advocate co-education to alleviate opposite gender anxiety and skeptics.
6. Provide them required opportunities to express their feelings and thoughts.
7. Making self desire strong enough.
8. Changing the surrounding environment.
9. Establishment of varied institutions for their better development.
10. Examining one's own conscious thoughts and feelings.
11. Should cultivate interest and likings.
12. An adolescent should make close friends with whom problems can be shared and sorted out.
13. An early decision is a quality that they should learn to adapt to the fast changing times.

Following the above said ways, if we struggle the sufferings of the world, then mental illness can be cured easily.
The science concerning mental health can be applied in any field. There is a saying,

***"Prevention is better than cure."***

It is better not to fall sick at first place than to be cured swallowing medicinal drugs. Also, it is better to try to keep a bad thing from happening than it is to fix the bad thing once it has happened. Preventing child's mental health deteriorating and promoting good mental health is a much better approach than dealing with later difficulties. Prevention is the key.

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